

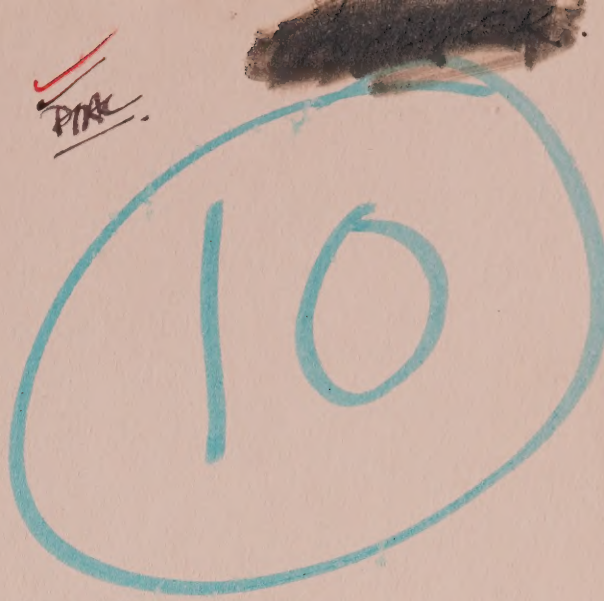


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ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND  
RELATED MATTERS.

Hearing held in Court Room 20  
Court House  
361 University Avenue  
Toronto, Ontario

*Silmon. Byson:*  
*in Ch*  
*X exam*

The Honourable Mr. Justice S.G.M. Grange

Commissioner

P.S.A. Lamak, Q.C.

Counsel

*Rose: in Ch.*

E.A. Cronk

Associate Counsel

Thomas Millar

Administrator

Transcript of evidence  
for

July 12th, 1983

VOLUME 10

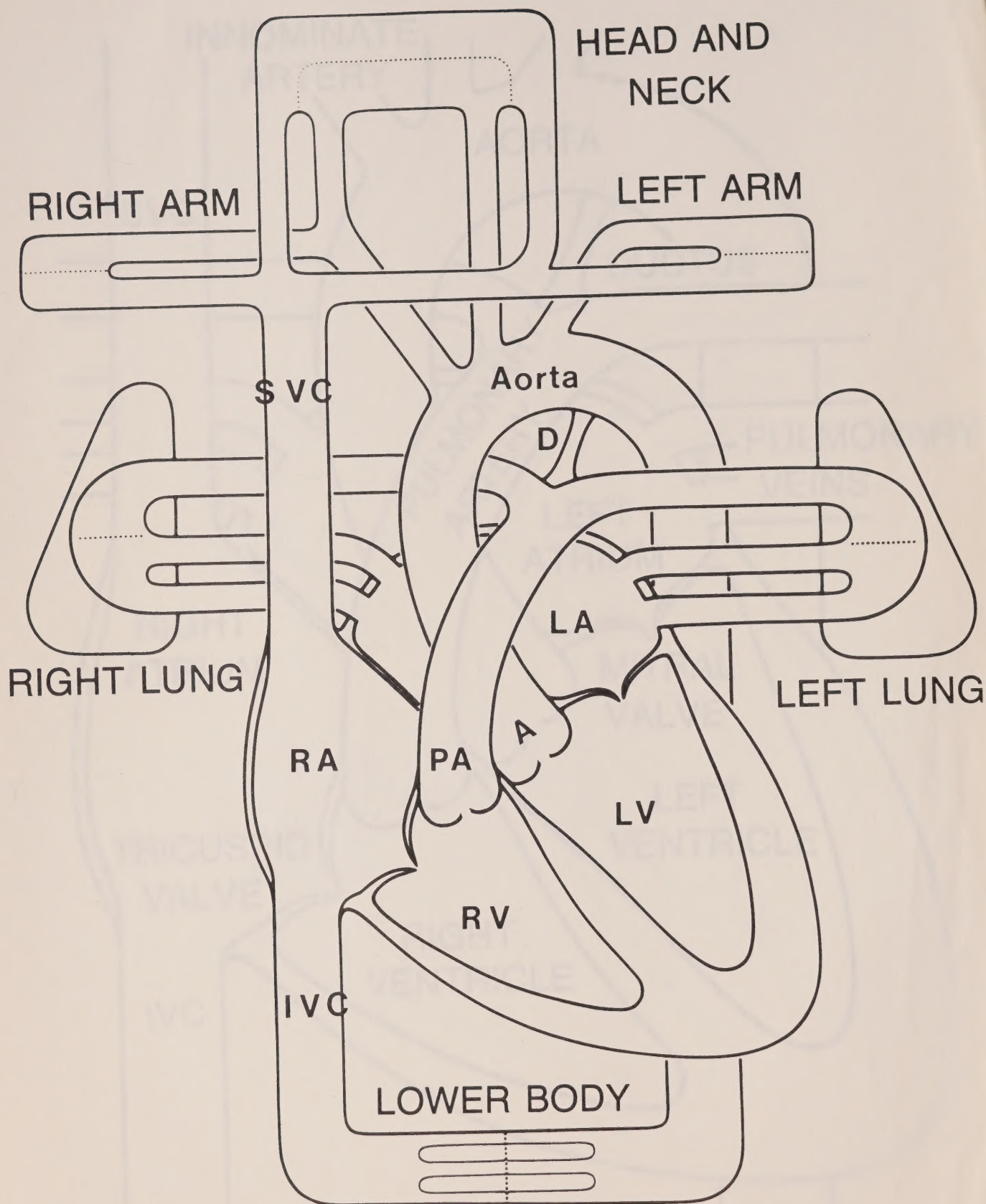
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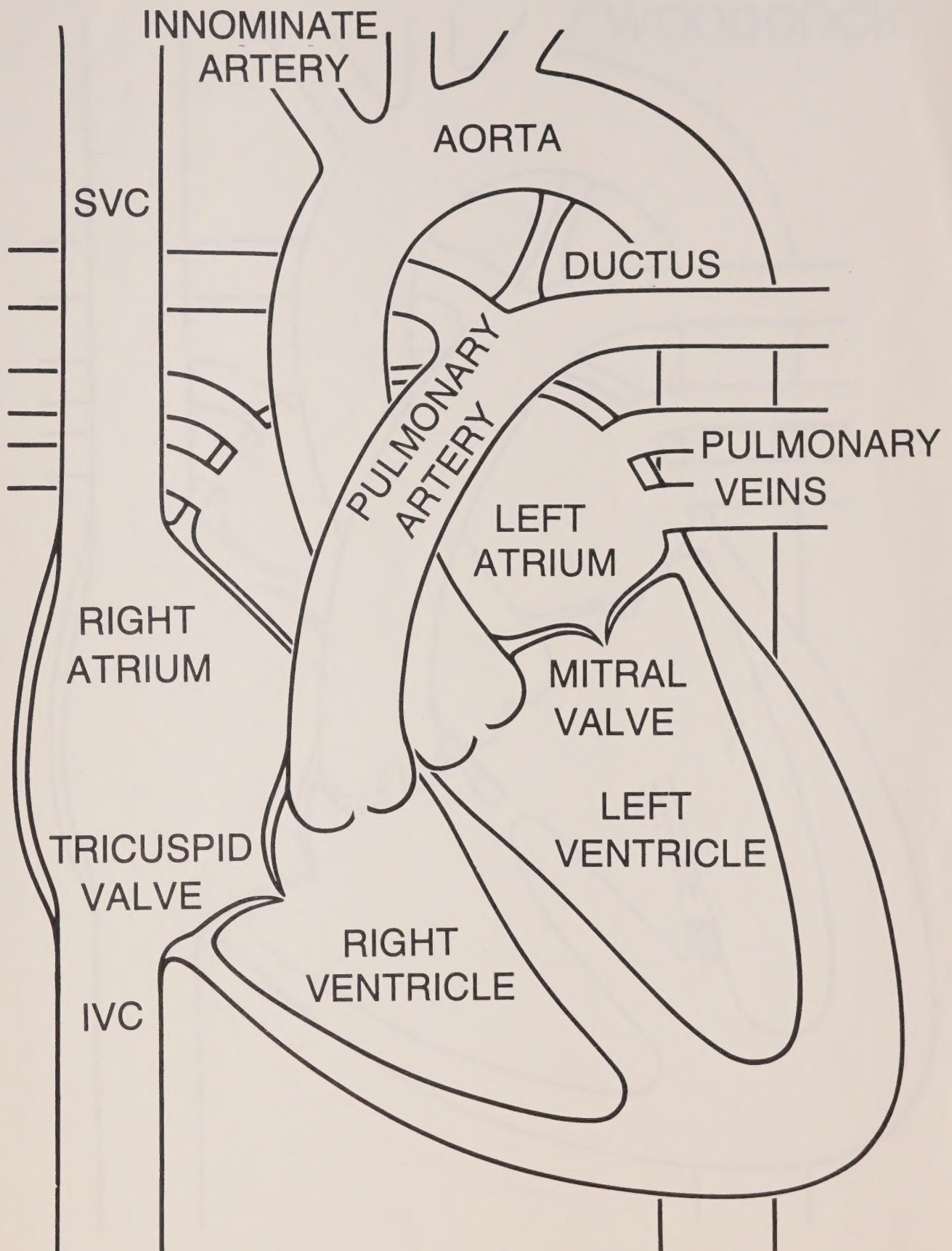











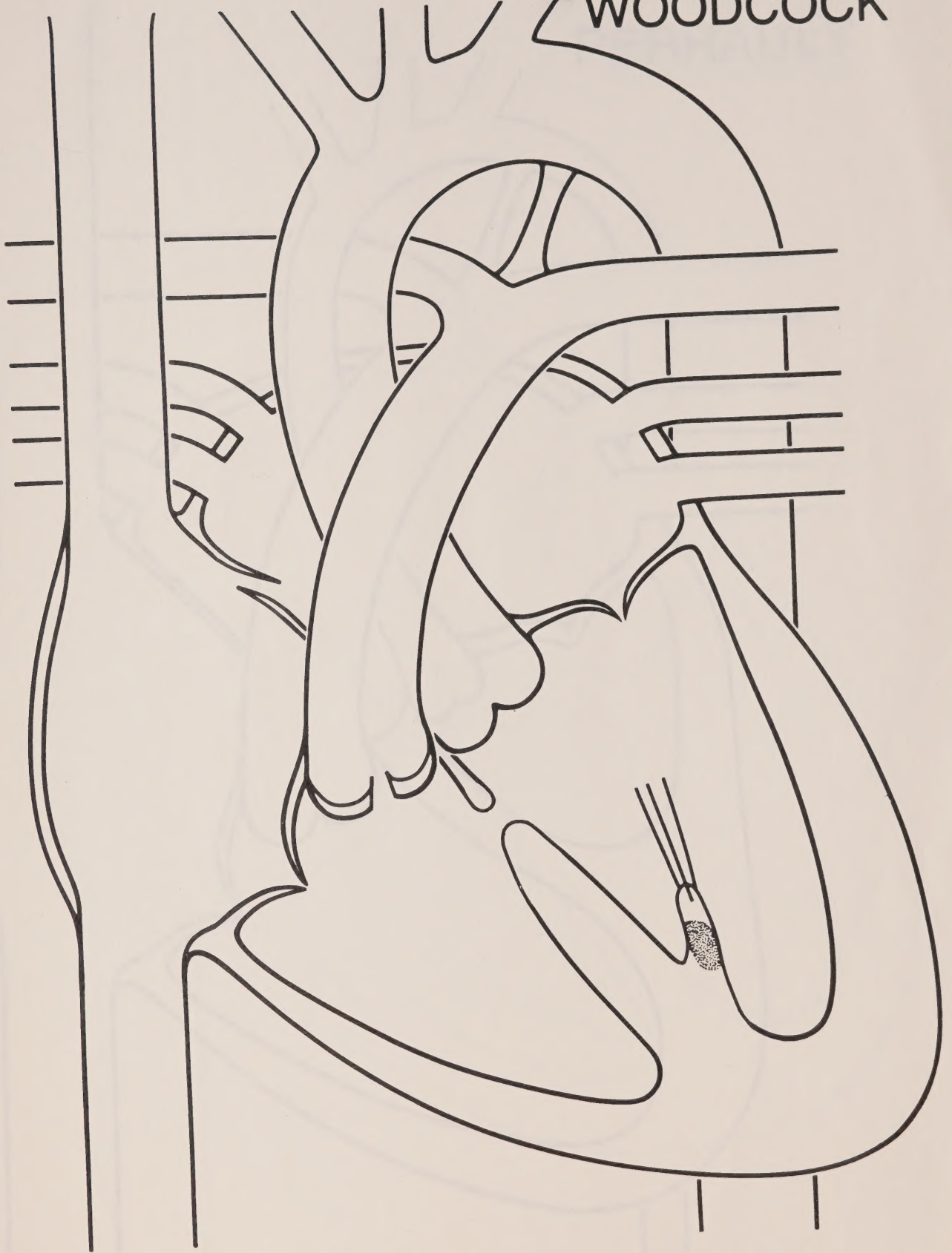




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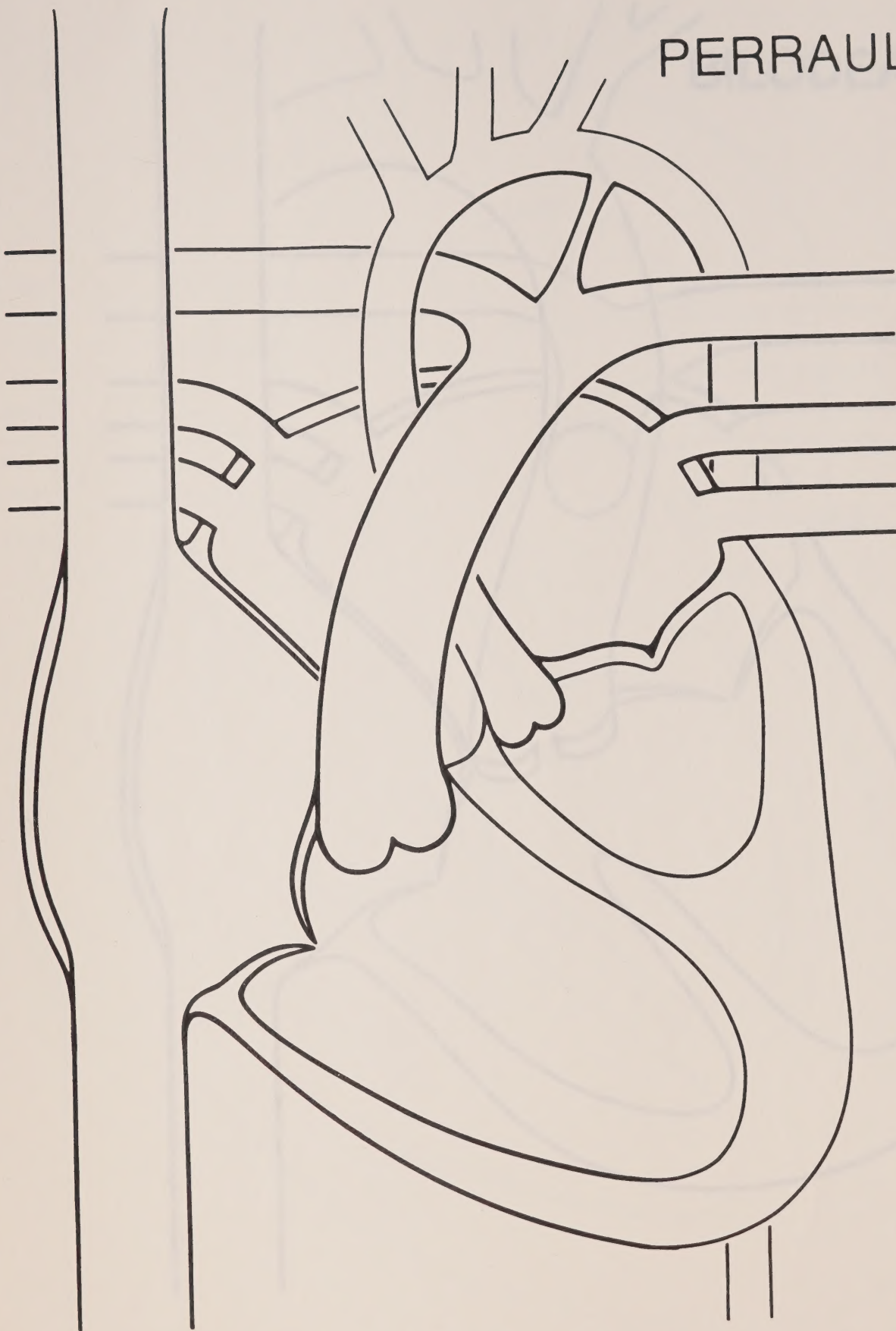
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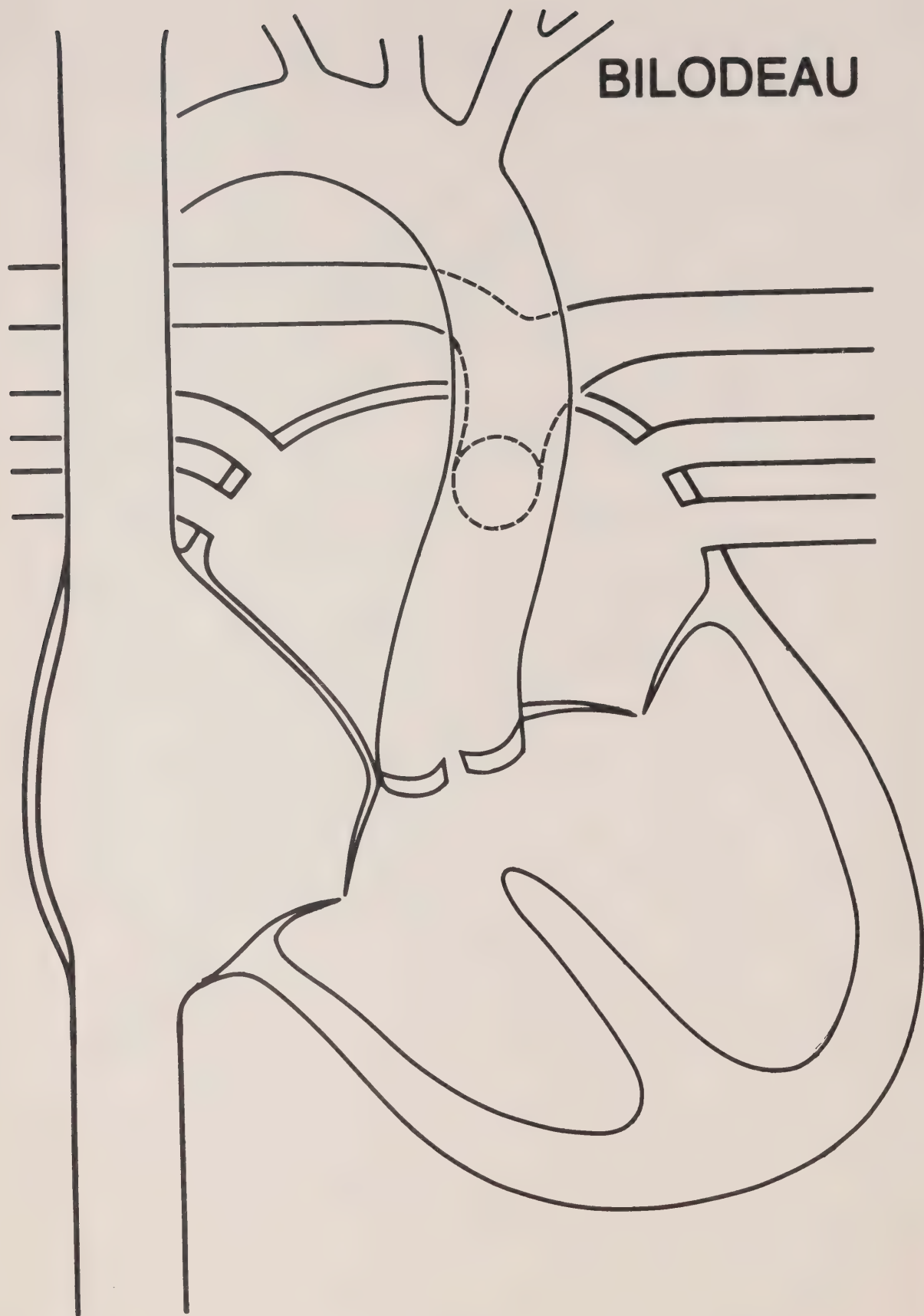
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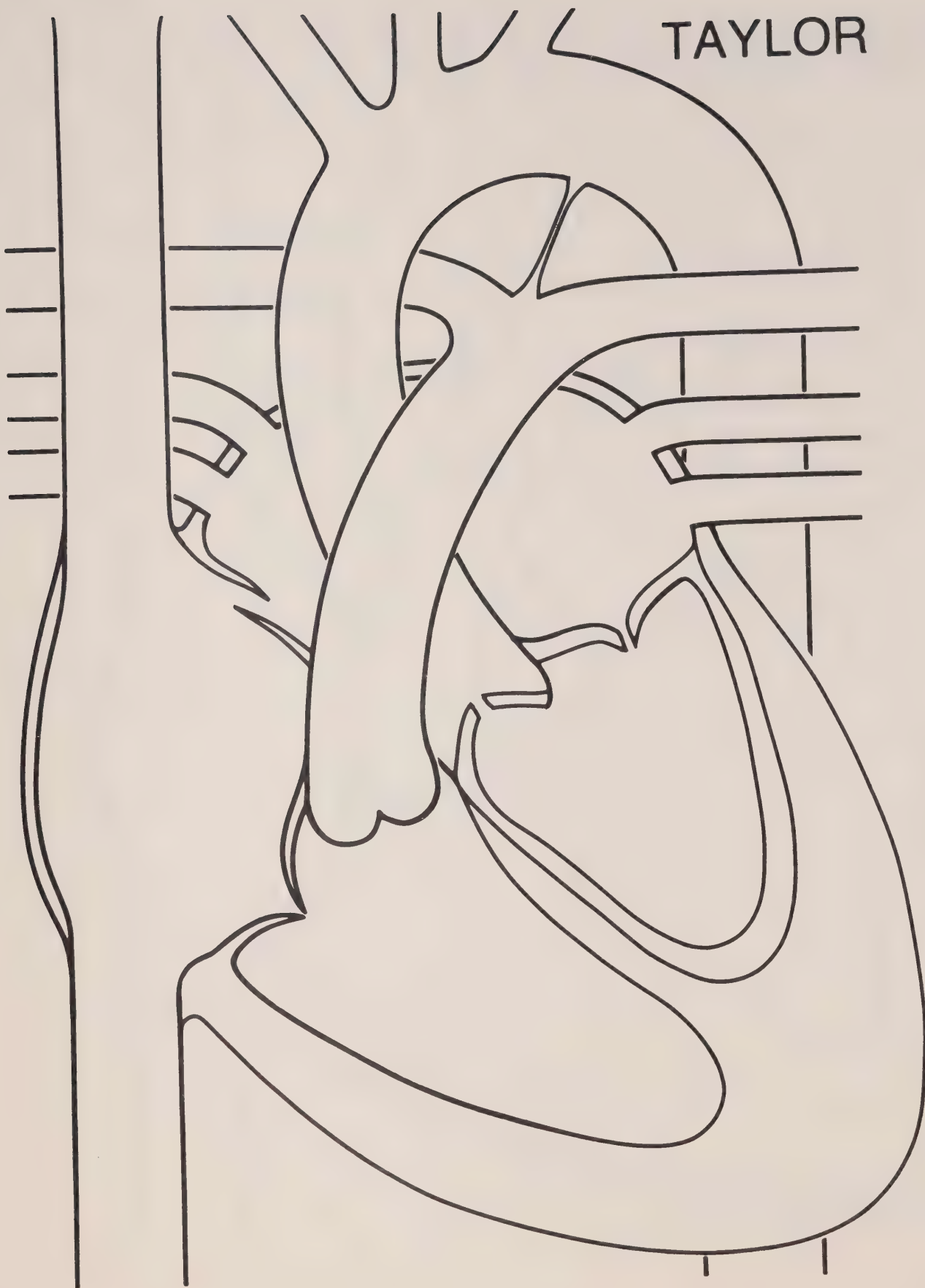


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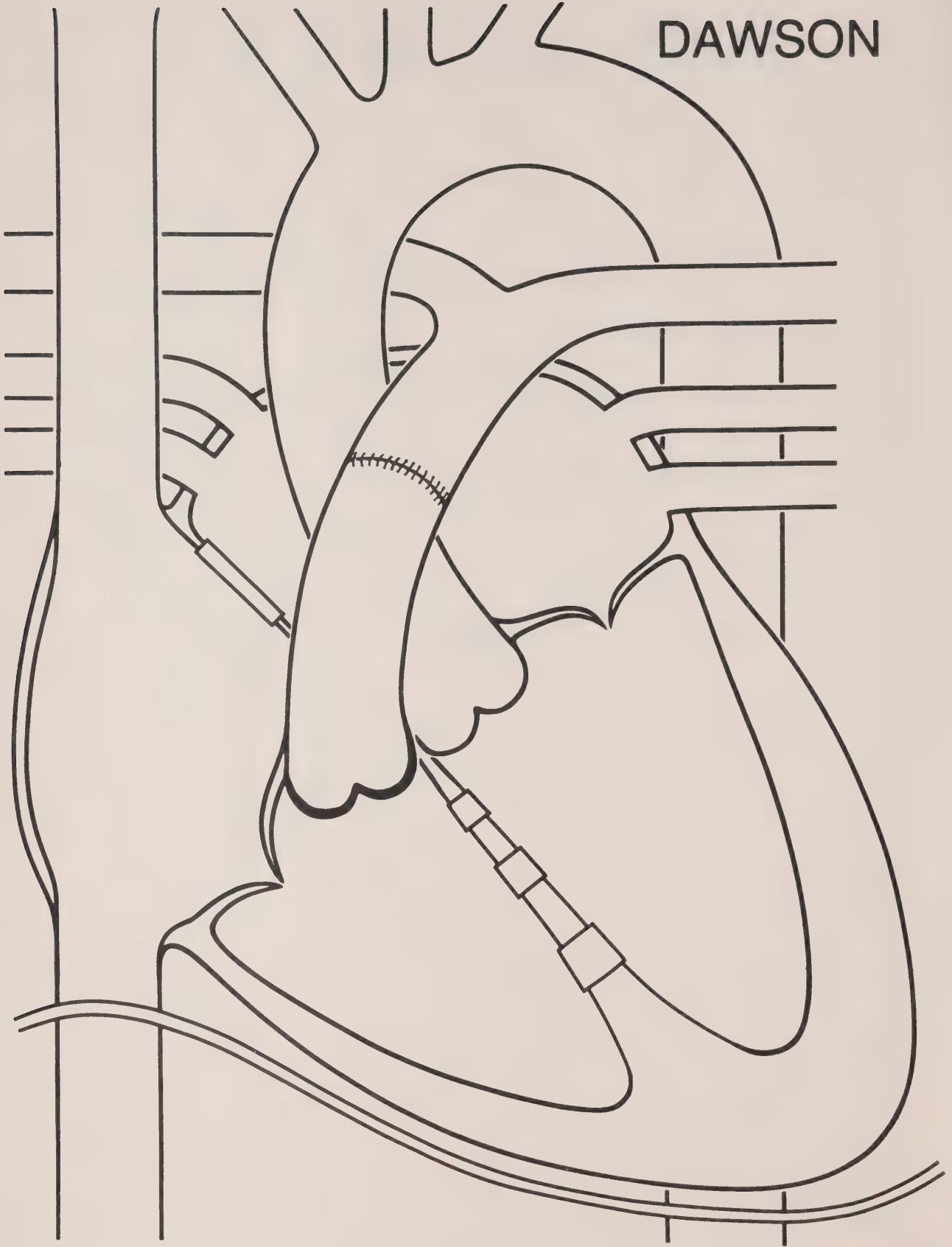
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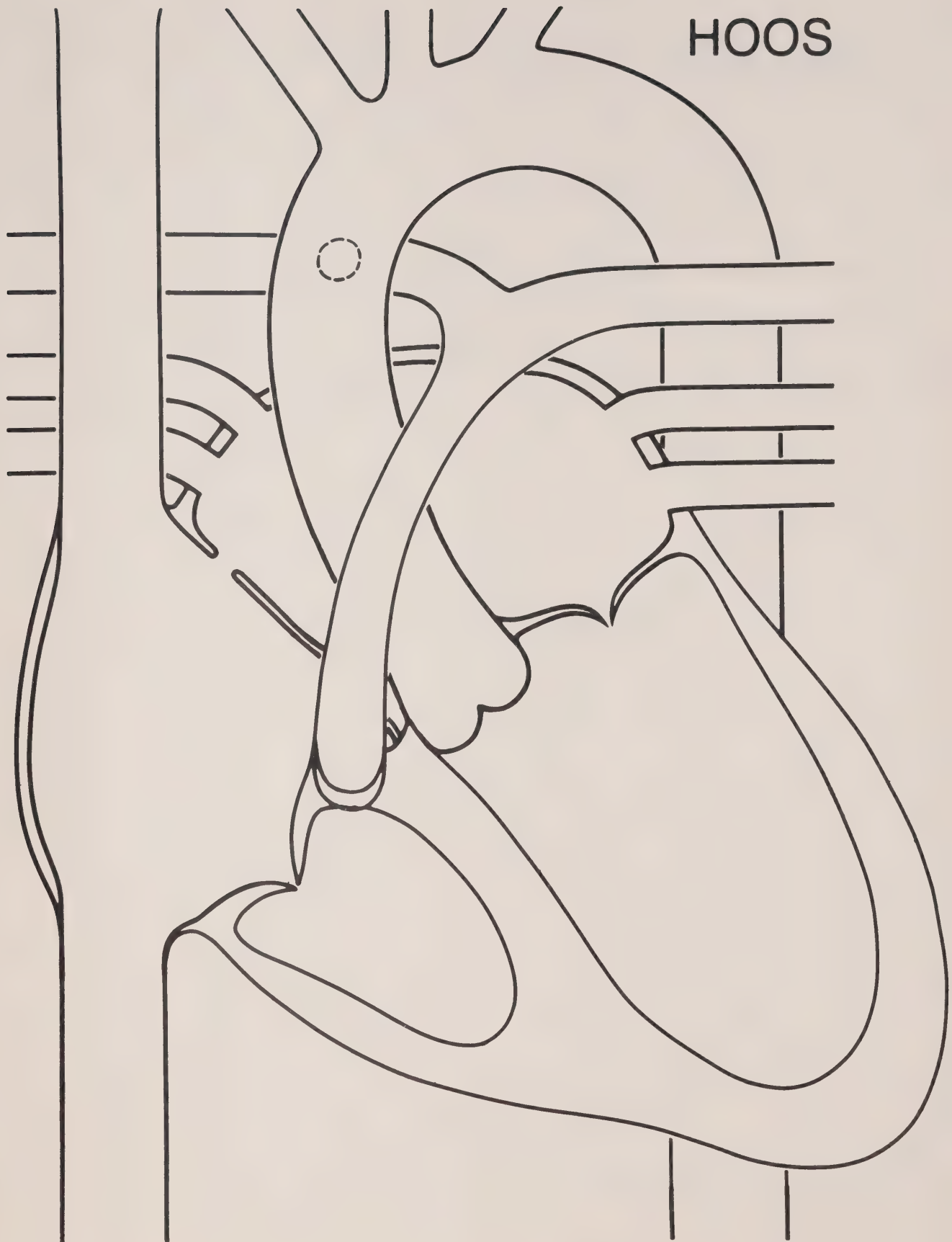
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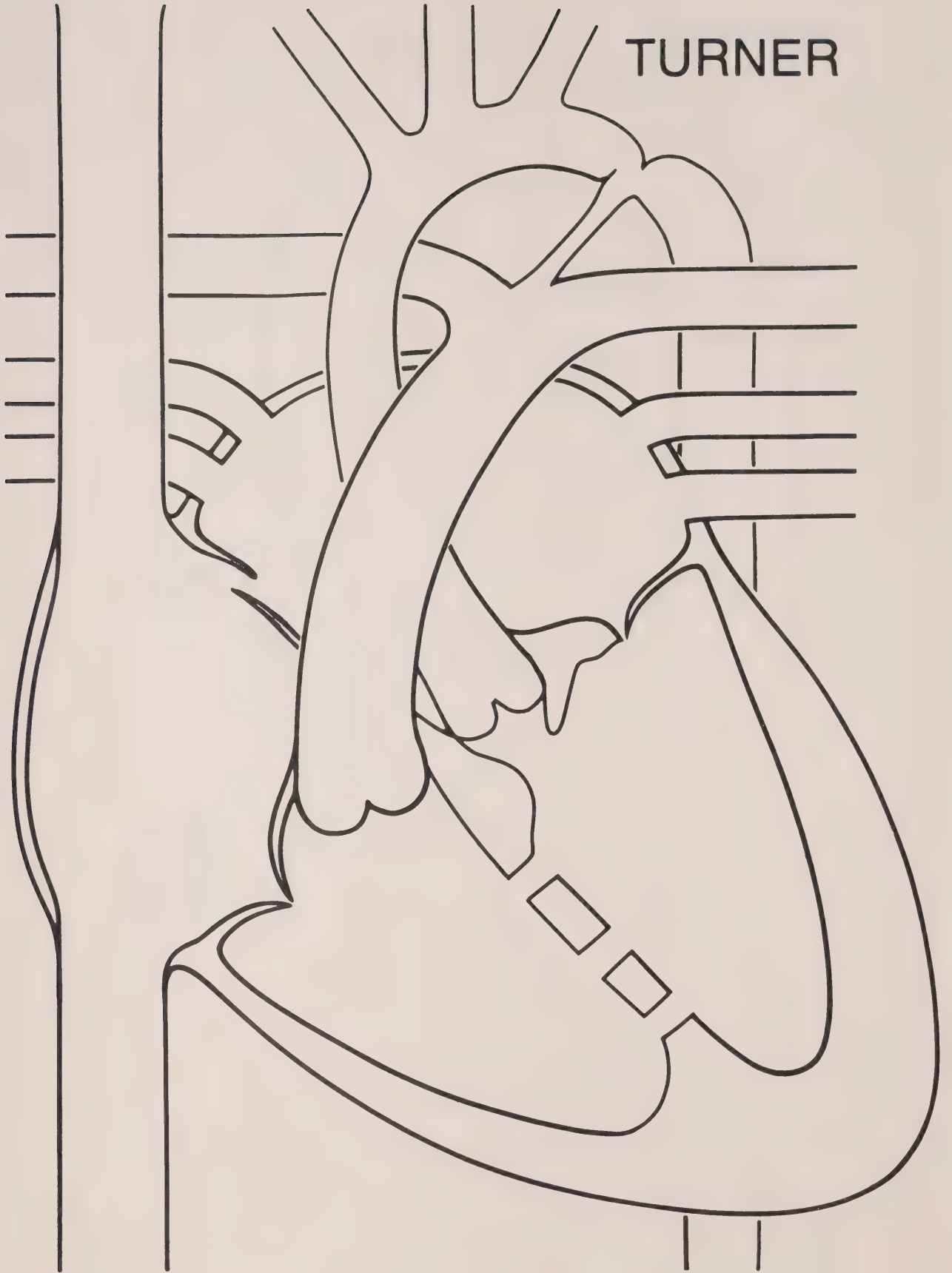


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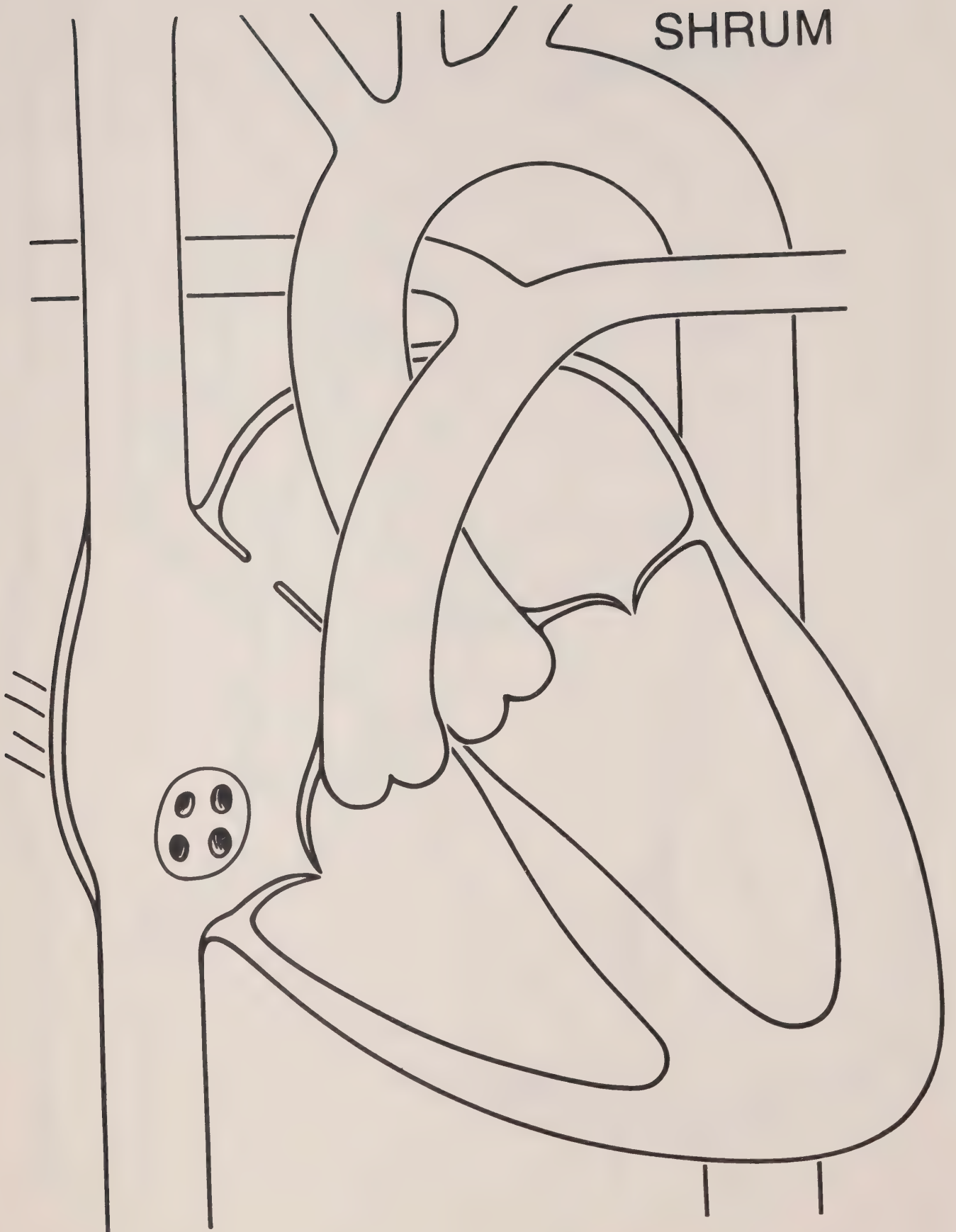
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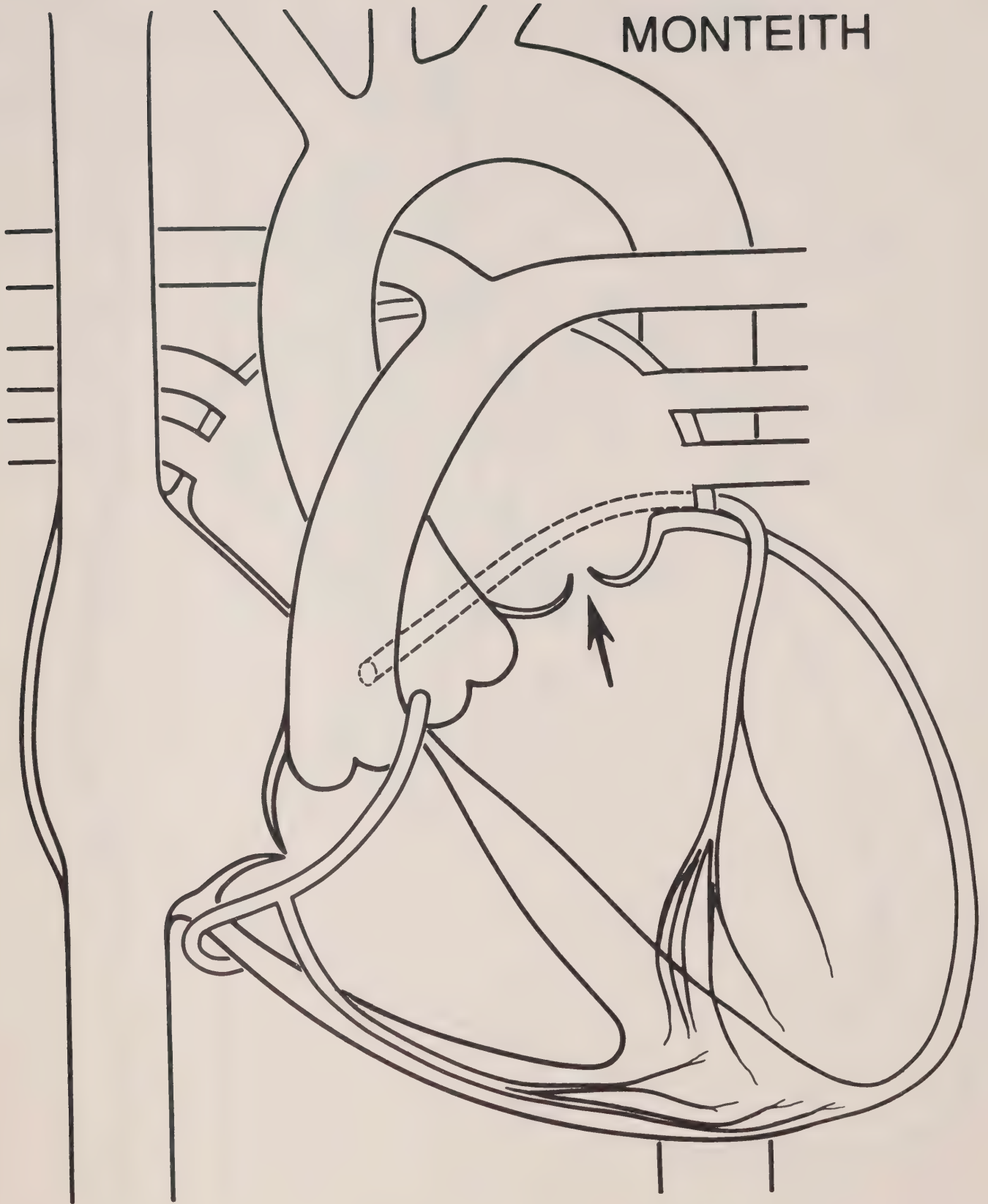


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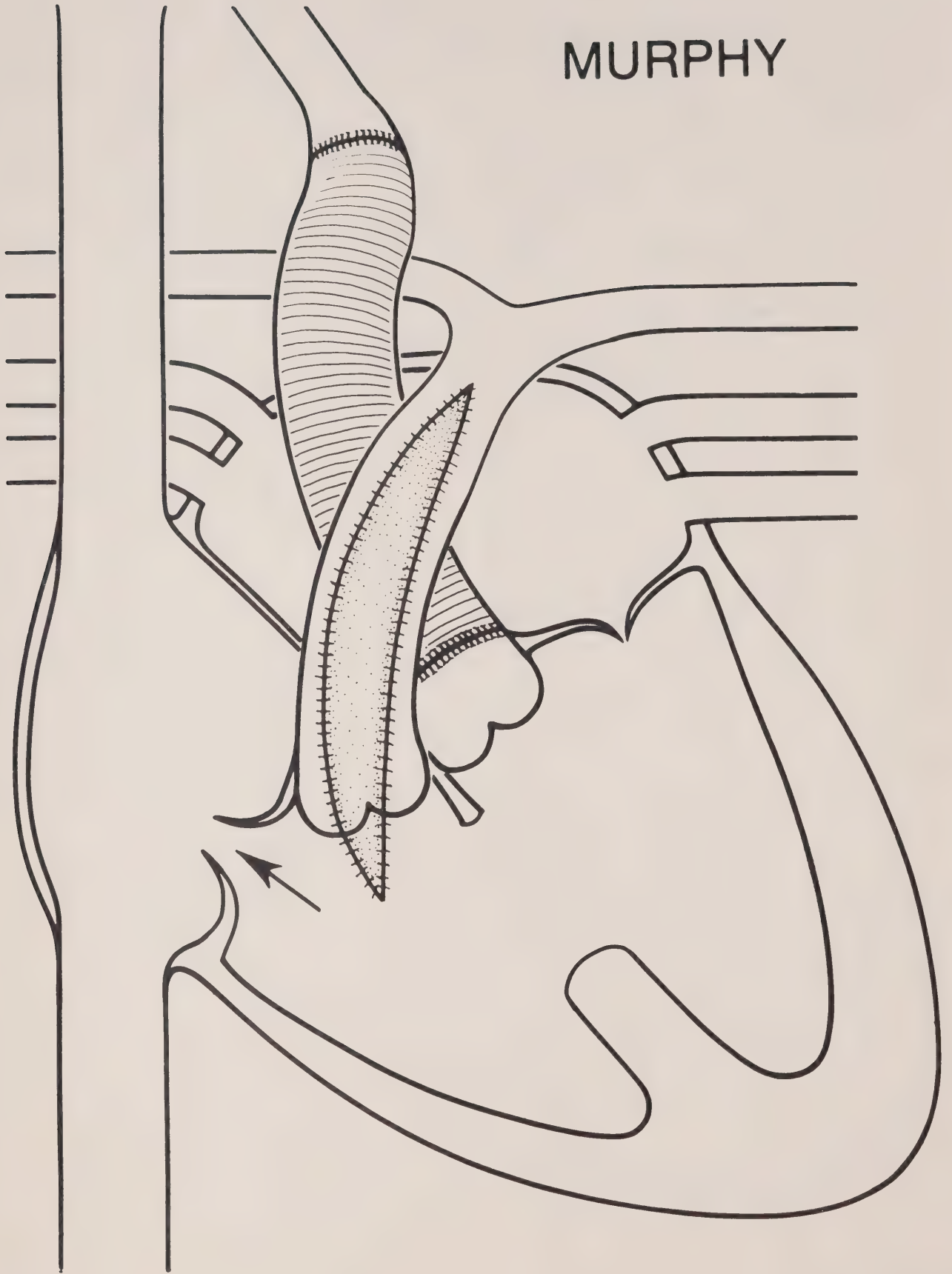
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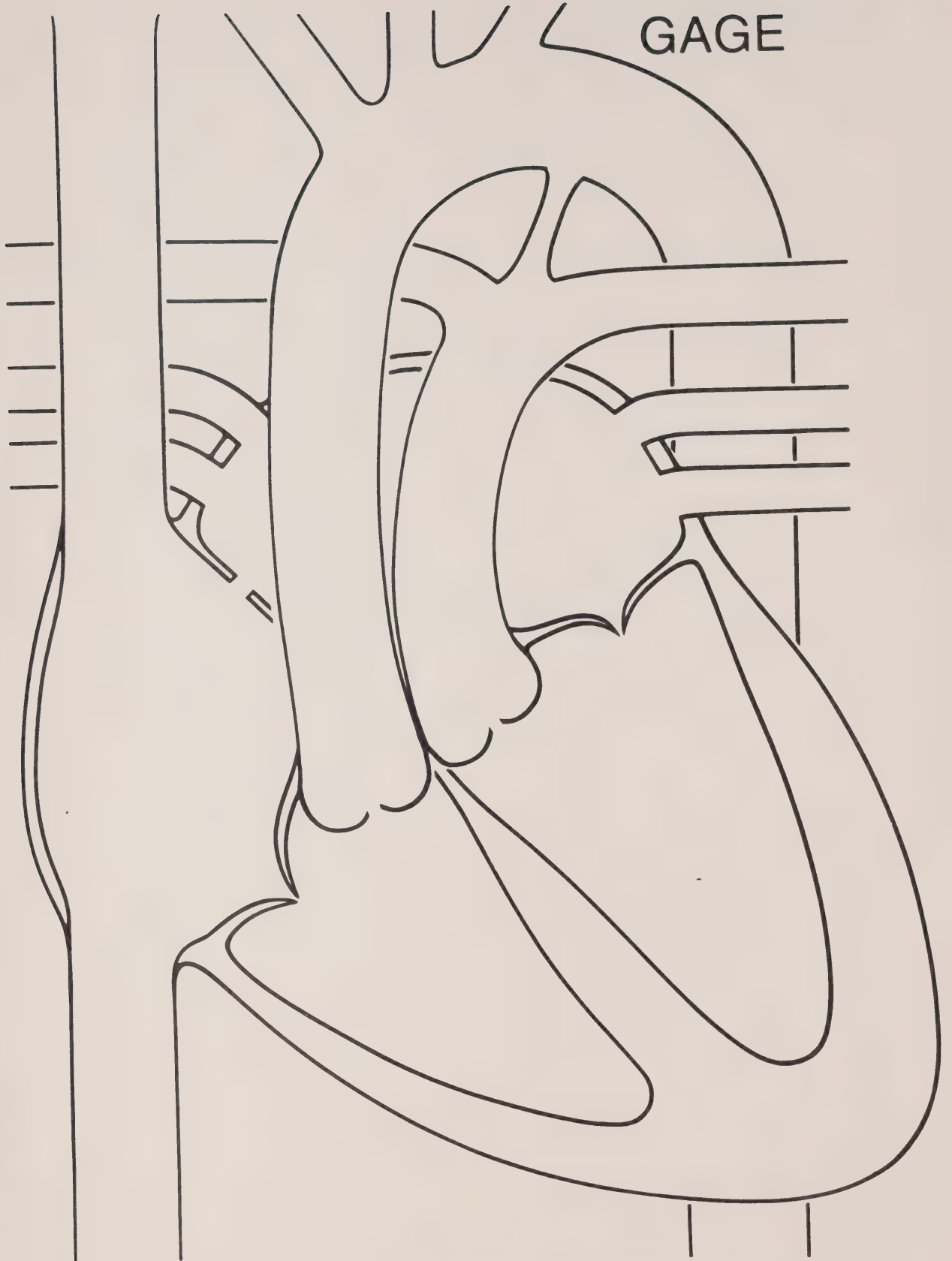


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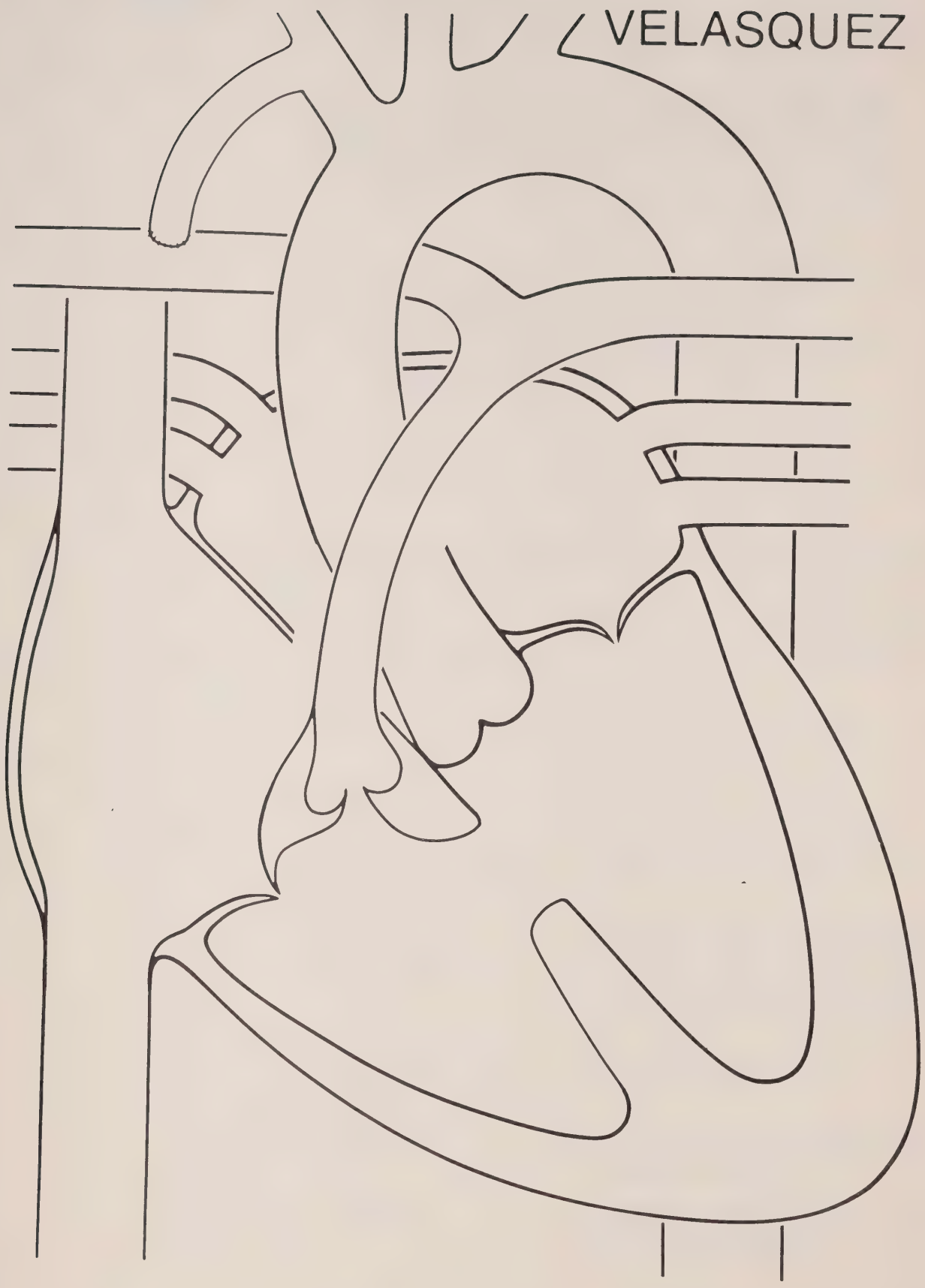
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VELASQUEZ







ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN  
AND RELATED MATTERS.

Hearing held in Court Room 20,  
Court House, 361 University  
Avenue, Toronto, Ontario, on  
Tuesday the 12th day of July,  
1983.

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner  
THOMAS MILLAR - Administrator  
MURRAY R. ELLIOT - Registrar

APPEARANCES:

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D. HUNT )	Counsel for the Attorney-
L. CECCHETTO)	General and Solicitor
	General of Ontario (Crown
	Attorneys and Coroner's Office)
I.G. SCOTT, Q.C.)	Counsel for The Hospital for
I. J. ROLAND )	Sick Children
R. DEVINS )	
D. YOUNG	Counsel for The Metropolitan
	Toronto Police
W.N. ORTVED	Counsel for numerous Doctors
	at The Hospital for Sick
	Children
E. SYMES	Counsel for the Registered
	Nurses' Association of Ontario
	and 35 Registered Nurses at
	The Hospital for Sick Children

(Cont'd)







APPEARANCES: (Continued)

H. SOLOMON	Counsel for the Ontario Association of Registered Nursing Assistants
W.A. BOGART	Counsel for Susan Nelles - Nurse
G.R. STRATHY) P. RAE )	Counsel for Phyllis Trayner - Nurse
B. JACKMAN	Counsel for Mrs. M. Christie - R.N.A.
J.A. OLAH	Counsel for Janet Brownless (Vereecken) - R.N.A.
M. MANNING) S. LABOW )	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes and Mr. & Mrs. Murphy (parents of deceased children)
W.W. TOBIAS	Counsel for Mr. & Mrs. Hines, (parents of deceased child Jordan Hines)
J. SHINEHOFT	Acting for Lorie Pacsai and Kevin Garnet (parents of deceased child Kevin Pacsai)
M. ROSENBERG	Counsel for Sui Scott - Nurse
F.J. SHANAHAN	Counsel for Mr. & Mrs. Dominic Lobardo (parents of deceased child Stephanie Lombardo)





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A/ EMT/ak

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---Upon commencing at 10:00 a.m.

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THE COMMISSIONER: Yes, Mr. Lamek?

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MR. LAMEK: Mr. Commissioner, before we start with this morning's oral evidence there are a couple of exhibits from last week that I would like to mark at this time if I may.

First I have photocopies of the two slides that were referred to and shown by Dr. Soldin during Miss Kitely's cross-examination of him. I wonder if those two together, Mr. Commissioner, might be the next exhibit, please.

12

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THE COMMISSIONER: Yes. What number are we at?

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---EXHIBIT NO. 29: Graphs numbered Figure 4 and Figure 5.

MR. LAMEK: Mr. Commissioner, I do not know if these photocopies have yet been made available to other counsel. If they have not, I can have copies made and distributed.

Do you have them?

THE COMMISSIONER: They seem to be ---

MR. LAMEK: Disinterested. It





1  
2 seems they have them.

3 THE COMMISSIONER: Well, they don't  
4 feel they have to answer these questions. However,  
5 they are available.

6 MR. LAMEK: They are not available  
7 today, Mr. Commissioner. They have not been distri-  
8 buted. I can get them done.

9 THE COMMISSIONER: All right.

10 MR. LAMEK: And second, Dr. Soldin  
11 provided two pages of data showing the comparative  
12 results achieved by RIA assays and FPIA assays,  
13 first on a number of autopsy post mortem samples,  
14 and second, on samples taken from neonatal subjects  
15 who had not received digoxin.

16 Now I wonder if this two-page  
17 document might be the next exhibit, sir?

18 THE COMMISSIONER: 30.

19 ---EXHIBIT NO. 30: Two-page document re Comparative  
20 Results achieved by RIA assays  
21 and FPIA assays.

22 THE COMMISSIONER: Again they are  
23 available if anybody wants them.

24 MR. LAMEK: Next, Mr. Commissioner,  
25 we have referred on a number of occasions to the  
Residents' Handbook of Pediatrics in the Hospital







1  
2 for Sick Children, and a few pages of that have been  
3 introduced. It seems to me it might make sense at this  
4 time to introduce the whole thing. The Hospital  
5 has kindly provided me with an additional copy.

6 I wonder if that might be Exhibit 31,  
7 please?

8 THE COMMISSIONER: Yes.

9 ---EXHIBIT NO. 31: Residents' Handbook of  
10 Pediatrics.

11 MR. LAMEK: Mr. Commissioner, since  
12 those cost \$15.00 each I am not offering to make  
13 those available to all counsel.

14 THE COMMISSIONER: No. All right.

15 MR. LAMEK: And then,  
16 Mr. Commissioner, we have recently furnished to  
17 counsel binders of the exhibits which were filed at  
18 the Preliminary Inquiry in the Queen against Susan  
19 Nelles. Those binders do not, of course, contain  
20 such demonstrative evidence as was filed, nor do  
21 they contain the Hospital's medical charts and  
22 records on any of the children who died. Those  
23 records and charts will be filed separately here as  
24 we deal with the deaths. But there is material  
25 among the exhibits from the Preliminary Inquiry  
which will be of use and assistance as we go along





1  
2 here, Mr. Commissioner, and I propose to mark the  
3 three volumes, the three binders of those exhibits  
4 as 32, perhaps A, B and C.

5 THE COMMISSIONER: 32A, B and C.  
6 They are in chronological order I take it?

7 MR. LAMEK: Sorry?

8 THE COMMISSIONER: In chronological  
9 order?

10 MR. LAMEK: In chronological order.

11 THE COMMISSIONER: We might have A  
12 which would be exhibits what to what?

13 MR. LAMEK: Exhibits 1 to 44.

14 THE COMMISSIONER: And B?

15 MR. LAMEK: 45 to 85, and C, 86 to  
16 122I.

17 THE COMMISSIONER: Yes. All right.  
18 Thank you.

19 ---EXHIBIT NO. 32A: Binder of Exhibits 1 to 44.

20 ---EXHIBIT NO. 32B: Binder of Exhibits 45 to 85.

21 ---EXHIBIT NO. 32C: Binder of Exhibits 86 to 122I.

22 MR. LAMEK: Mr. Commissioner, may I  
23 call please as the next witness Dr. Anne Gilmour-  
24 Bryson.  
25





1  
2 DR. ANNE KATHLEEN RITCHIE GILMOUR-BRYSON, Sworn  
3 DIRECT EXAMINATION BY MR. LAMEK:

4 Q. Dr. Gilmour-Bryson, we are about  
5 scientific and medical matters here, so I had better  
6 make it clear right away you are not a medical doctor,  
7 are you?

8 A. No.

9 Q. Indeed you are a Doctor of  
10 Philosophy, and I believe an historian, holding an  
11 appointment in the Department of History at Glendon  
College of York University?

12 A. Yes.

13 Q. And Dr. Gilmour-Bryson, your  
14 area of special interest in which you have published  
15 is interestingly that of the Knights Templar  
16 and their trials in the 14th Century on charges of  
heresy and other nasty misdeeds?

17 A. Yes, it is.

18 Q. I understand that it was in  
19 the course of your research in that area, in your  
20 reading of medieval manuscripts and transcripts of  
21 depositions - I gather hundreds of depositions in  
22 those proceedings - you began to make use of  
electronic data storage and retrieval techniques?

23 A. Yes.  
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Q. You computerized, as the word has it, the information in the medieval source documents, and were thus better able to sort, integrate and retrieve the information?

A. Yes, that is correct.

Q. I suppose the obvious question, Dr. Gilmour-Bryson, is what is a good historian like you doing in a case like this, but as I understand it following the discharge of Susan Nelles at the Preliminary Inquiry in May of 1982 you offered your services to and were retained by the Ministry of the Attorney-General to assist and to apply your computer techniques to the ongoing investigation of the deaths at the Hospital for Sick Children?

A. Yes.

Q. And in particular as I understand it you were retained to compile a data base, stored on a computer, comprising information relevant to the investigation and capable via electronic data retrieval techniques of being sorted and organized in many different ways and of being quickly retrieved by the investigator?

A. Yes, indeed.

Q. And you carried out that project, did you?





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A. Yes.

3

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Q. And in the spring of 1983 when this Royal Commission was established you were retained as a consultant to the Commission to assist in the marshalling and retrieval of information relevant to our work, were you not?

8

A. Yes, I was.

9

10

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13

14

Q. And Dr. Gilmour-Bryson, I call you as a witness today to give evidence about just one aspect of the work that you have done. It may be that it will be that you will appear later with respect to your participation in the investigation by the police, but at the present time I am just interested in one aspect.

15

16

17

18

In assisting in the police investigation did you compile information as to the number of deaths on or associated with the Cardiology Wards at the Hospital in the period from July 1980 until March 1981?

19

20

A. Only in respect to Wards 5A, 4A and 4B.

21

22

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Q. And did you similarly compile information as to deaths on those wards or associated with those wards in the periods on either side of the one I have just identified: that is





1  
2 both before July, 1980 and after March of 1981?

3 A. Yes, I did.

4 Q. For how a long period prior to  
5 July, 1980 did you gather statistics?

6 A. Initially for 12 months on  
7 either side of the investigative period; 12 months  
8 before and 12 months after. A little later it  
9 became advisable to go back to January 1st, 1979,  
10 so I went back in fact to January 1st, 1979. And  
11 since I was doing this in the summer of 1982 I could  
12 go no farther than the summer of 1982.

13 Q. Dr. Gilmour-Bryson, how and  
14 from what sources did you obtain information as to  
15 the deaths on or associated with the Cardiology Wards  
16 in the periods that you have just identified?

17 A. I requested of the Hospital  
18 Administration who through their Records Department  
19 gave me the names and history numbers, dates of  
20 death and times of death and place of death, of  
21 children associated with 5A initially and then 4A  
22 and 4B.

23 Q. And since your retainer as a  
24 consultant to this Commission have you at my request  
25 rechecked and confirmed and in one respect extended  
the information as to deaths at the Hospital?

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Q. And have you yourself checked the Hospital records and information that was furnished to you in compiling this information?

A. Yes. I have rechecked all the information given to me with all charts except one which apparently is temporarily mislaid, but the other 195-odd charts I have checked in the last 10 days.

Q. And when you say given to you, given to you by whom?

A. The charts given to me by whom?

Q. The charts given to you by whom?

A. By the Records Department of the Hospital for Sick Children.

Q. Would you tell me the nature of the records you have examined?

A. I have examined the charts for each child and in order to get names and history numbers of children I have also gone through death notices which are documents the Hospital also keeps on file in its Records Department in order to attempt to find all the children I could who were associated with 5A, or 4A and 4B during the period in question.

Q. And have you, Dr. Gilmour-Bryson, from the records and information made available to you by the Hospital, counted deaths either on or associated





B.2

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with the Cardiology Wards in five nine-month periods?

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That is to say, first from January 1, 1979 until

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September 30th, 1979; second from October 1st, 1979

5

until June 30th, 1980; third from July 1, 1980 to

6

March 31, 1981; fourth from April 1st, 1981 until

7

December 31st, 1981; and fifth from January 1, 1982

8

until September 30th, 1982?

9

A. Yes, that is correct.

10

11

Q. And have you, at my request,

prepared a number of graphs and/or charts showing

deaths in those periods?

12

A. Yes, I have.

13

14

Q. Did you, Dr. Bryson, prepare a

chart of the deaths in the five periods showing all

ward-associated cardiac deaths whether they occurred

15

on the Cardiac Ward, or in the Operating Room, in the

16

case of a child who had gone from the Cardiac Ward,

17

or in the Intensive Care Unit in the case of a child

18

going from the ward to the Operating Room to Intensive

19

Care Unit, or directly from ward to Intensive Care

20

Unit?

21

A. Yes, I did, but I would like to

22

say again that I am only dealing with 5A, 4A and 4B,

23

not all Cardiac Wards.

24

Q. I see.

25





B.3

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A. There may be other cardiac patients elsewhere.

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Q. Can we perhaps see the first of the charts that you so prepared, I understand it is called "Total Death by Period"?

5

6

Now, Mr. Commissioner, copies of these charts have been been available for counsel since Friday but if anyone doesn't have his own copy yet there are copies available here for them.

7

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9

10

Now, could you explain to me first, Dr. Bryson, so that we are absolutely clear, what you mean by "Total Deaths"? What deaths are included on this chart?

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14

A. In this chart I have included the deaths of all children known by me to have been admitted to Wards 4A or 4B, or before that 5A, who subsequently died either on the ward or in the Operating Room, or in the Intensive Care Unit from the Operating Room, or in the Intensive Care Unit from the ward.

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Q. Do I understand that each of the children whose deaths are tallied and shown on this chart had during the period of his last admission to the Hospital spent time on Ward 5A, or 4A, or 4B?

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A. Yes, I do not take into account

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a child who may have been on 4A or 4B or 5A at some other period. It is the period of death which I am concerned with here, the death must fall within the nine months' stated time period at the foot of the graph.

Q Along the bottom of the chart are shown the five periods that I identified earlier?

A Yes, indeed.

Q And the tally, the total of deaths is shown on the left side of the graph?

A The left is a simple scale and the bars are drawn to scale to represent the totals which are shown for each period above the bar, the total deaths for Period 1 would be 30; for Period 2 it would be 32; for Period 3 it would be 64; for Period 4, 29; and Period 5, 28.

Q And Period 3 is the period referred to in the Terms of Reference of this Commission is it not, Dr. Gilmour-Bryson, from July 1, 1980 to March 31st, 1981?

A That is correct.

Q I think even I can understand that chart, Dr. Gilmour-Bryson. I wonder, Mr. Commissioner, if that, a copy of that chart might be made the next exhibit?





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THE COMMISSIONER: Yes.

Exhibit 33, Chart - "Total Death by  
Period, Each Period Nine Months."

--- EXHIBIT NO. 33: Chart: "Total Death by Period,  
Each Period Nine Months."

MR. LAMEK: Q A couple of questions  
about that if I may, Dr. Gilmour-Bryson. One, the  
Terms of Reference of this Commission refer to  
children who died in Cardiac Wards in the period  
July 1, 1980 to March 31st, 1981. As I understand it  
this chart includes the deaths of children who although  
they spent some time on 5A, 4A and 4B, may have died  
elsewhere, that is to say in the Operating Room or the  
ICU?

A. Yes, indeed it does.

Q Can you tell me why we are  
interested in children who died elsewhere in this  
count?

A. It really has been done in order  
to attempt to look at the death rate from different  
points of view. It is important I think, and we are  
later going to look at the death rate on the ward  
itself, children who died actually present on the ward.  
But in order to get any idea of the meaning of that  
particular number of children who died on the ward, I  
think it is important to know how many children





B.6

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actually died in all three places associated with that ward, since a number of factors can affect that total figure.

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Q. Perhaps that will be explained more clearly when we see the next chart. Thank you for that.

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Second, about this chart, you have referred to Wards 5A, 4A and 4B, and we know of course that until April of 1980 the Cardiology Ward was 5A on the fifth floor of the Hospital, but as of April 1, 1980 it was moved to Wards 4A and 4B on the fourth floor of the Hospital?

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A. Yes.

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Q. And we also know that when that move occurred and the Cardiology Ward became 4A and 4B, there was an increase in the total number of cardiology beds, that 4A and 4B combined were bigger than 5A had been?

21

22

23

24

25

A. Yes.

Q. By, as I recall it, some four or five beds?

A. Four infant beds, I believe.

Q. Overall beds were increased by four, is your recollection?

A. Yes.







B.7

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Q. And they were infant beds?

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A. Yes, I understand that is correct.

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Q. Did your counts, or your - or  
do your charts, Dr. Gilmour-Bryson, make any adjustment  
for those increases in the number of infant or total  
beds after April 1, 1980?

8

9

10

A. No, they do not. These charts  
show the simple total figures and have not been  
increased or decreased to allow for the difference in  
ward size.

11

12

Q. There is no judgmental factor  
in adjustment of the figures?

13

A. None at all.

14

15

Q. Now I understand that you have  
prepared a list of the names of the children whose  
deaths are represented on this chart by period?

16

A. Yes, I have.

17

18

19

Q. In each of the five-month  
periods. I am showing to you a copy of that list, is  
that the list that you prepared?

20

A. Yes, it is.

21

MR. LAMEK: Mr. Commissioner, may that  
be Exhibit 33-A, it goes with the chart.

22

THE COMMISSIONER: Yes.

23

24

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--- EXHIBIT NO. 33-A: List of names of children  
by period.





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MR. LAMEK: Q. Now, Dr. Gilmour-Bryson,

3

I am showing now to you on the screen a chart headed

4

"On Ward Deaths by Period", is this the chart that

5

you prepared?

6

A. Yes, it is.

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Q. And, similarly, could you define the heading, please, what are On Ward Deaths?

A. On Ward Deaths mean that the infant actually died physically present on the ward and not later in the ICU or in an emergency operating room, he or she actually died on the ward, present on the ward.

Q. And when you say on the ward, are we again referring only to 5A, 4A, 4B?

A. Yes, we are referring to exactly the same five nine-month time periods and the same wards as we used before in the same order.

Q. And again we have the periods identified along the bottom of the chart and the scale along the left side showing the five periods, five deaths, six deaths, 34 deaths, one death and seven respectively.

A. Yes, that's correct.

MR. LAMEK: Mr. Commissioner, may that be the next exhibit, please, Exhibit 34.

THE COMMISSIONER: Exhibit 34.

---EXHIBIT NO. 34: Chart headed "On Ward Deaths by Period".

MR. LAMEK: Q. And similarly, Dr. Gilmour-Bryson, I will show to you a list of





1  
2 names by period and alphabetically within each  
3 period, which I understand you prepared identifying  
4 the children whose deaths are charted on Exhibit 34.

5 A. Yes, I did. That's a copy of  
6 the list.

7 MR. LAMEK: 34A, please,  
8 Mr. Commissioner.

9 THE COMMISSIONER: Yes.

10 ---EXHIBIT NO. 34A: List of names by period in  
11 alphabetical order.

12 MR. LAMEK: Q. Doctor, we have  
13 just spent a moment on the two charts which are now  
14 marked as exhibits. The total death chart, Exhibit  
15 33, as you have told us is all cardiac deaths  
16 associated with Wards 5A, 4A, 4B including the  
17 deaths of those children who died either in the  
18 operating room or in the Intensive Care Unit, having  
19 spent time on one of those three wards.

20 A. Yes, that's correct.

21 Q. Am I able therefore to establish  
22 by simply process of arithmetic deduction, the  
23 number of operating room and ICU deaths shown on  
24 Exhibit 33 by subtracting from the totals there  
25 shown the numbers shown on Exhibit 34?

A. Yes. I have in fact divided







1  
2  
3 them into two groups, those who died in the ICU  
4 from the ward and those who died in the operating  
5 room or in the ICU, but if you put those two  
6 groups together and add them to these, you will get  
the totals you saw on the chart.

7 Q. Okay. Now, no doubt other  
8 people in this room are much better at arithmetic  
9 than I am, Dr. Gilmore-Bryson, but can you help me?  
10 In period one, that is to say from January 1, '79  
11 until September 30, 1979, can you tell me, please,  
12 how many deaths occurred in the operating room and  
13 in the ICU of children who had spent time in that  
stage Ward 5A?

14 A. Well, according to my figures,  
15 four children died in the operating room itself,  
16 18 children died in the ICU.

17 THE COMMISSIONER: I'm sorry, which  
period?

18 THE WITNESS: Period one, sorry.

19 MR. LAMEK: Period one,  
20 Mr. Commissioner.

21 THE WITNESS: Period one.

22 THE COMMISSIONER: Four?

23 THE WITNESS: Four children died in  
24 the operating room, 18 children died in the ICU from  
25





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the operating room without returning to the ward  
and three children died in the ICU from the ward  
without having, in that immediate transfer, moved  
via the operating room.

6

MR. LAMEK: Q. Thank you. And  
those three numbers added together come to - please?

7

8

A. I hope so.

9

Q. I'm sorry, what was the total?

10

A. I haven't - we have 3 and 22,  
25 and 5 on the Ward.

11

12

Q. That comes to the 30 shown in  
Exhibit 33?

13

A. Yes.

14

15

Q. What about period two, could  
you give me the same breakdown for that period, please?

16

17

18

19

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A. Yes, in period two, four  
children died in the operating room, nine children  
died in the ICU from the operating room, an unusually  
low number which I would like to point out, and  
three children once again died in the ICU from the  
ward, plus six.

21

Q. And that comes to 22, does it?

22

A. Yes.

23

24

25

Q. In period three, please, the  
period which is under review in this Commission.





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A. In period three, nine children died in the operating room, 19 children died in the ICU from the operating room, two children died in the ICU transported directly from the ward and 34 died on the ward.

Q. For a total of 64 shown in Exhibit 33?

A. Yes.

Q. The numbers please for period four?

A. Period four, if you will excuse me for a moment while I find my place, period four, five deaths in the operating room itself, 19 deaths in the ICU from the operating room, three deaths in the ICU from the ward and unusually only one on the ward.

Q. And finally in period five, please?

A. Period five, in the operating room itself one, in the ICU from the operating room 17, in the ICU from the ward three and on the ward seven.

Q. For a total 28.

THE COMMISSIONER: There's something wrong. One in the operating room, 17 in







1

2

the ICU from the operating room and three in the ICU.

3

MR. LAMEK: From the ward.

4

THE COMMISSIONER: From the ward.

5

I make 21.

6

MR. LAMEK: Plus the seven who died

7

actually on the ward.

8

THE WITNESS: The seven on the ward.

9

THE COMMISSIONER: But I have a

total figure of 27.

10

MR. SCOTT: Mr. Commissioner hasn't

11

perhaps seen the last page, Mr. Lamek.

12

THE COMMISSIONER: Oh, is there

13

something else?

14

MR. LAMEK: Ah! Yes, there was

15

another death disclosed from the Hospital records  
only last week I think.

16

THE WITNESS: Yes, after we had

17

made the original set of graphs.

18

MR. LAMEK: Q. You were notified by

19

the Hospital last week of one further death?

20

A. Yes, I was, which was very

21

kind of them to do so.

22

MR. SCOTT: Mr. Lamek, do I under-

23

stand from that then that 27 should really read 28  
on the graph.

24

25





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THE WITNESS: Yes. On our original  
graphs it is 28.

4

5

MR. LAMEK: On the graph that's  
been marked an exhibit, yes.

6

7

THE WITNESS: We had the graph re-  
made after your copies were made.

8

9

MR. LAMEK: Q. Just going back to  
Exhibit 33, in fact, the graph shows the 28.

10

11

THE COMMISSIONER: Which does?

MR. LAMEK: The one that is flashed  
up here, Mr. Commissioner.

12

13

THE COMMISSIONER: Oh, yes, but not  
on the one I've got, oh, I see.

14

15

MR. LAMEK: Those were printed  
and ready for distribution before the final death  
came to anyone's attention.

16

17

18

19

20

Q. Now, Dr. Gilmour-Bryson, in your  
review of the Hospital's records for the information  
as to deaths in the periods, did you make any note,  
or were you able to make any note as to the time at  
which a death occurred?

21

22

23

24

25

A. Yes, I did.

Q. And from what source were you  
able to establish that?

A. Well, the time of death is





1  
2 stated on some computer printouts the Hospital have  
3 been making for the last couple of years; that's one  
4 source. In the chart itself, there is a time of  
5 death stated on the autopsy report or the final  
6 autopsy report or the autopsy and discharge report,  
7 in the front of the chart as a rule. There is a  
8 time listed also on the yellow or blue admitting  
9 sheet for that infant, pencilled in I presume in  
10 the Record Department. Since there was considerable  
11 variance in the times in these three or four sources  
12 in the records, in every case, I went to the actual  
13 death notes on that baby filled out by usually a  
14 nurse and a doctor both in which normally both the  
15 nurse and the doctor state baby pronounced dead at  
16 a certain time and, in the case of operating room  
17 deaths, an operating room nurse or doctor or both  
18 write that in at the bottom of the yellow operating  
19 room sheet.

20 So, in every case I choose the time  
21 specified by the nurse and doctor if it was in  
22 variance from these other times that appear elsewhere  
23 in the other records.

24 Q. And did you compile a list or  
25 a record showing the time of death of each child who  
died on the ward, the deaths which are shown on





1

2

Exhibit 34, for each of the five nine-month periods?

3

A. Yes, I did.

4

Q. And did you, using those

5

data, prepare a chart plotting the on ward deaths

6

for each of the five periods and showing the times

7

of day at which deaths occurred?

8

A. Yes, I did.

9

Q. Okay, thank you. I am showing

10

to you now, Dr. Gilmour-Bryson, on the screen a

chart headed "On Ward Deaths by Time", and I ask if

11

that is the chart you prepared?

12

A. Yes, it is.

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Q. Now this one is rather differently constructed from the others. And let me be sure that I understand it. Do I have it correctly that on this chart each period is identified by a different colour?

A. Yes. In all the charts actually.

Q. Yes. You are quite right.

A. But not in the Xeroxes.

Q. But the periods on the other charts were plotted along the bottom of the graph?

A. Yes.

Q. What we have along the bottom of this graph is 1, 2, 3, 4, 5, 6 four-hour periods?

A. Yes.

Q. You have broken the 24-hour day into six four-hour periods and have shown, if I understand this correctly, by colour coded columns the number of deaths from each period that occurred in each four-hour period?

A. Yes. Only deaths on the ward.

Q. On the ward?

A. Yes.

Q. In other words if I want to know how many children died on the ward in Period 5 between





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the hours of nine o'clock in the morning and one o'clock in the afternoon I would go to that four-hour time period along the bottom, identify the colour associated with Period 5, which is the red colour, and plot that against the scale on the left hand side?

A. Yes, exactly. And the five nine-month periods, of course, remain the same as they have in every chart, and the dates remain the same.

Q. Right. Exactly the same five nine-month periods and again to be sure that I understand, Period 3 is the period in which we are particularly interested in this Commission, that rather attractive magenta colour.

A. That is correct.

Q. And the chart records that 24 children in that nine-month period died on the ward between the hours of one o'clock and five o'clock in the morning?

A. Yes. One minute past one and five o'clock, just so the two time zones don't each have the same number.

Q. Absolutely.

MR. LAMEK: Mr. Commissioner, may that be the next exhibit, please?

THE COMMISSIONER: Yes. 35.





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--- EXHIBIT NO. 35: Document headed:  
"On-Ward Deaths  
by Time".

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THE COMMISSIONER: It is between 0101  
and 0900 is it?

5

6

THE WITNESS: 0101 and 0500, Mr.  
Commissioner, is the first one. They are four-hour  
periods.

8

THE COMMISSIONER: I see.

9

10

11

MR. LAMEK: Q And finally, Dr. Gilmour-  
Bryson, did you with this chart as with the others,  
prepare a list of names of those children whose deaths  
are represented on Exhibit 35?

12

13

A. Yes, I did.

14

15

Q I am showing to you a list. Do  
you recognize that as the one you prepared, Dr. Gilmour-  
Bryson?

16

17

A. Yes, I do.

18

MR. LAMEK: Exhibit 35-A, please, Mr.  
Commissioner.

19

THE COMMISSIONER: All right.

20

--- EXHIBIT NO. 35-A: Document headed:  
"On-Ward Deaths  
by Time".

21

22

MR. LAMEK: Dr. Gilmour-Bryson, thank  
you very much.

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24

Perhaps you would stay there. My  
friends may have some questions of you.

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THE COMMISSIONER: Any particular  
order, gentlemen?

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Mr. Bogart?

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6

MR. BOGART: Sir, it is my understanding  
that, or I would submit that it would be appropriate  
for the Hospital to cross-examine first.

7

8

THE COMMISSIONER: Well, I don't know.  
Mr. Scott, you don't find that is appropriate?

9

MR. SCOTT: No, I don't.

10

11

THE COMMISSIONER: Well, I don't think  
we can force it upon him. Does anyone else want to  
let Mr. Bogart off the hook at the moment?

12

13

MR. SCOTT: Can we take five minutes,  
Mr. Commissioner? This examination finished a little  
faster than we perhaps expected.

14

15

THE COMMISSIONER: Well, all right.

16

MR. SCOTT: Three minutes?

17

18

THE COMMISSIONER: No, no, we will  
take five minutes if that is enough.

19

--- Short recess

20

--- Upon resuming:

21

THE COMMISSIONER: Yes, Mr. Bogart?

22

MR. BOGART: Sir, I am prepared to go  
first.

23

24

THE COMMISSIONER: You can't very well  
do it without the witness.

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Yes, Mr. Bogart.

MR. BOGART: Thank you, sir.

CROSS-EXAMINATION BY MR. BOGART:

Q. Dr. Gilmour-Bryson, I just have a few questions.

I don't believe we were provided with a copy of a CV for you, were we?

A. No, I don't believe you were.

Q. Can you tell us where you obtained your Ph.D., Doctor?

A. My Ph.D.?

Q. Yes.

A. And M.A. at the Institut d'Etudes Medievales, Université de Montréal.

Q. Thank you, Doctor.

Just one more question on the background. Can you tell us have you ever done any other consulting work of a similar kind to the work that you have done --

A. Well, I have.

Q. -- that you discussed here today?

A. I have been asked to advise the Canadian National Council on Computing in the Humanities, and I also have had to advise on research projects for the National Endowment in the Humanities in the United





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States and publish and lecture constantly on computer applications with indexing and historical data.

Q. I see. But may we take it from that that this is the first project that you have been retained on where you are analyzing deaths in hospitals?

A. No, because I am analyzing deaths in the middle ages constantly.

Q. Yes.

A. For seven years.

Q. Yes, thank you, Doctor, but other than that.

Dr. Gilmour-Bryson, you said when you initially began to analyze the deaths that I believe you picked a 12-month period before and after the period July, 1980, to March, 1981?

A. Yes.

Q. Have I got that right?

A. Yes.

Q. And then you said that it became advisable to extend your research?

A. Yes.

Q. Can you just tell the Commissioner why it was that you concluded that it would be advisable?

A. I thought it would be wise to go





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as far back as was reasonably possible; therefore to go back to January 1st instead of to July 1st, since at this point I was also able to go forward, since it was mid summer and I was able to get some hospital deaths from the mid summer period I was able to go forward for 15, 16 months, I wished to go backward the same length of time as I went forward. So the two periods prior and after would be of the same length.

Q. Thank you.

And then you told the Commissioner I believe in your evidence in chief that when 5A became 4A and 4B that the number of beds increased by four. But I don't believe you said what the total number of beds were on 4A and 4B - sorry, 5A and 5B?

A. My understanding is 32 on 4A and 4B versus 28 on 5A.

Q. I see. And then in respect of the five periods I note when you gave a breakdown of the deaths and where they occurred that in Period 2 there were four deaths in the operating room and nine deaths in the intensive care unit. Have I got that right?

A. Period 2?

Q. Yes.







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A. Yes.

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Q. And in Period 3 there were nine

4

deaths in the operating room and nineteen deaths in

5

the intensive care unit?

6

A. That is correct, from the

7

operating room in both cases, yes.

8

Q. So as with Mr. Lamek I am not

9

very good at arithmetic, but I take it that the first

10

total is 13 and the second total is 28?

11

A. That is correct.

12

Q. So that comparing Period 2 to

13

Period 3, we see an increase of over double in terms

14

of the number of deaths on the operating room ICU from  
Period 2 to Period 3?

15

A. That is correct.

16

Q. And I take it, Dr. Gilmour, that

17

you are not in a position to offer any explanation  
as to the cause of the increase?

18

A. No, I am not, except that

19

Period 2 is a period of very low deaths amongst the

20

five periods which can be seen from the graph, but I am  
not in a position to explain why.

21

Q. And then finally in respect of

22

the deaths on the ward, you gave a breakdown by time?

23

A. Yes.

24

25





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Q. That is Exhibit 35 I believe?

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A. Yes.

4

Q. I wonder if you could tell me

5

did you do a similar breakdown for deaths that  
occurred other than on the ward?

6

A. Yes.

7

Q. In the operating room, in the

8

ICU, that sort of thing?

9

A. Yes, I did.

10

Q. Do you have that breakdown

11

readily at hand?

12

A. I have one here of total deaths -

13

James, it is either 7 or 8 - of the other periods. By  
time, you are referring to time? Deaths by time?

14

15

Q. Yes, ma'am.

16

A. I have two that relate to the

17

other periods, Graph 7 and Graph 8, which we haven't  
duplicated or put figures with because I had no idea  
whether anyone would want them.

19

Q. Well, just so that I understand

20

what information you have. You have information  
concerning when deaths occurred.

21

22

A. Yes.

23

Q. For deaths that occurred other

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than on the ward?

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A. Yes. Yes, James, they are the  
handmade two graphs there.

This was Ward ICU deaths which is a  
very small number of deaths, please remember, in all  
periods that is the time from the way it looks for  
these Ward ICU deaths.

Q. Yes.

A. But as I say, it is a very small  
total number of deaths. And the other one is all  
deaths for the other periods. That is those deaths  
occurring in the operating room, in the ICU and so on.  
That is the way that one looks by time.

Q. So the first one is the ICU?

A. Yes. First one is from the  
ward to the ICU, and the second one is all of these  
other period deaths charted by time.

Q. I see.

MR. BOGART: Well, Mr. Commissioner, I  
don't wish to take up any further time, but I wonder  
if I might have access to those documents to have a  
look at them?

THE COMMISSIONER: There is no reason  
why they couldn't be made an exhibit if you wanted  
them.

THE WITNESS: I would like to make a







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list to go with them if you don't mind, Mr. Commissioner

3

THE COMMISSIONER: Yes, all right.

4

THE WITNESS: Of just what deaths are  
included.

5

6

THE COMMISSIONER: Yes. Then we will  
delay that until we can - but there is no reason why  
you can't see them now if he wants to.

8

THE WITNESS: Oh, no, of course.

9

10

MR. BOGART: Thank you, sir. I would  
be obliged for the information.

11

THE COMMISSIONER: Mr. Strathy?

12

CROSS-EXAMINATION BY MR. STRATHY:

13

Q Doctor, I would like to just  
go back a little bit to discuss your profession and  
the work that you do, and I take it that you would  
call yourself an historian?

15

16

A. An historian, yes, and a  
computer expert.

17

18

Q A computer expert? Well,  
dealing with your historical side of things, I take  
it that it is medieval history, is it?

19

20

A. Yes, it is.

21

22

Q And is that what your Ph.D.  
related to?

23

A. Yes.

24

25





D.12

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Q. And do you teach at Glendon?

3

A. No, I don't. I am a Research

4

Fellow doing full-time writing and publishing.

5

Q. At Glendon?

6

A. A computer analysis of the

7

Templar trials under a post-doctoral grant from the

8

Social Sciences in the Humanities, Research Council  
of Canada, in legal research by computer.

9

Q. That is the specific research

10

you are doing at the moment?

11

A. Yes.

12

Q. And your educational background

13

I take it was primarily in history, was it?

14

A. Not really because in - I

15

believe I attended university for a total of 13 years,

16

and part of that was in economics and statistics and

17

business; part of it was history, part of it was

18

literature; part of it was psychology. Six languages.

19

I really have a background in a wide variety of

20

subjects.

Q. When did you become a computer

21

expert?

22

A. It is when I was working on my

23

Ph.D., starting in 1974, I began to use a computer in

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1974 on a daily basis.

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Q. I see. So the experience you have had with it has been basically research experience?

A. Yes. Research and publishing.

Q. The work that you told us about today would appear at least to not involve the use of computers to any great extent?

A. No.

Q. It was simply a matter of manually toting up the number of deaths in a particular period?

A. That is right.

Q. Coming up with totals and then reproducing the results in graphic form?

A. Yes.

Q. Have you, apart from your work with the Knights Templar, or your study of the Knights Templar, have you had any experience with respect to hospitals?

A. No, none at all.

Q. So this is really a first incursion at least in modern day hospitals?

A. Yes. Some experience with medieval hospitals.

-





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Q. In terms of your own work, have you taken any courses or done any work with respect to statistics?

5

6

7

A. Only computer statistics courses that as I took as an undergraduate, I do not prepare any applied statistics.

8

9

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Q. You don't prepare any?

A. No, I do not ever prepare any applied statistics. Statistics courses are designed to teach you how to apply complicated interpretive statistics, probabilities and so on, which I do not engage in at all, all I am doing is very simple arithmetic.

14

15

16

Q. So that is not something that you do either in your daily work, nor is it what you have tried to do?

17

18

19

A. No, I use the Statisticians of York University Institute of Behavioural Research for the statistical work I require for my own historical projects.

20

21

22

Q. I am just trying to be clear. You haven't applied statistics with respect to the work you have told us about this morning?

23

24

25

A. No, not unless you mean counting and dividing.







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Q. No.

3

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A. And the percentages, no,  
no probability statistics in that, no interpretive  
statistics.

5

6

7

8

9

Q. I would just like to be clear on  
exactly how it came to be that you became involved  
in these matters. Was it you who approached the  
Attorney-General, or the Attorney-General's Office  
approached you?

10

11

A. I approached the Attorney-  
General.

12

13

Q. And what was the reason for  
that approach?

14

A. What was the reason for that?

15

Q. Yes.

16

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25

A. Because I had received the  
Social Sciences and Humanities Research Council of  
Canada Post Doctoral Fellowship for two years for  
a project in Medieval Legal Computer Research. I  
had stated at that time, in my application, that in  
my opinion the same procedures would be applicable  
to modern legal problems, and so I was interested  
in proving this to the Government, that it would in  
fact be applicable to modern legal problems as well  
as medieval.





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2

3

Q. And when was it that you made  
this first approach?

4

5

6

7

A. I couldn't tell you the exact  
date, but it was after the conclusion of the  
Preliminary Hearing, I suppose early June of 1982?  
Yes.

8

9

10

11

Q. Now you have told us about  
certain work that you have done in relation to this  
project and I gather there is other work you have  
done that you haven't told us about as yet?

12

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14

15

A. Yes.

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Q. Can you tell us briefly what  
it is? Let me perhaps first ask Mr. Lamek whether  
it is definitely the intention to call this witness  
at some later stage, and if so, when, that would be?

MR. LAMEK: Certainly Dr. Gilmour-  
Bryson will be back to speak of her contribution,  
whatever it may be called, to the investigative  
activities of the police and the Attorney-General's  
Ministry. That is not likely to be until we get  
into that phase of the Inquiry, Mr. Commissioner,  
in the Fall some time. Dr. Gilmore-Bryson will be  
back to speak about those things.

23

24

25

MR. STRATHY: All right.

Q. I would like to understand at





1  
2 this point, at least in a summary fashion, Doctor,  
3 what it was that you did in relation to these other  
4 matters that you have not yet told us about?

5 MR. LAMEK: Mr. Commissioner, I  
6 note the rooted objection to this, but for  
7 the life of me I don't see its relevance to the  
8 evidence that Dr. Bryson has given today about the  
charts and counting deaths.

9 THE COMMISSIONER: No, it may not  
10 be, but can we not get a general nature of what it is?

11 MR. LAMEK: There is no mystery  
12 about it.

13 THE COMMISSIONER: What it is,  
14 what the other aspects of your investigation are.

15 THE WITNESS: Primarily ---

16 THE COMMISSIONER: Without coming  
out with the facts.

17 THE WITNESS: No, no. Primarily  
18 preparation of a data base including certain informa-  
19 tion from the charts in respect to the 46 deaths  
20 which the police had under investigation.

21 Secondly, assisting the investigators,  
22 or the Crown whenever possible, in producing lists  
23 of any type of data they required that I could make  
24 for them, making simple graphs of the type that you  
25





1  
2 have seen here. No interpretive graphs, but simple  
3 graphs of numbers.

4 Looking up what drugs different  
5 babies had, or what formulas different babies had.  
6 Providing a series of information, normally in  
7 numerical form to the police, or to the Crown upon  
8 request.

9 MR. STRATHY: Q. And all that is  
10 work that was done by you subsequent to June 1982?

11 A. Yes. After I began working,  
12 which was the day after Dominion Day of that year  
13 which I think, that was the 1st, I think it was  
14 July the 5th that I started.

15 Q. So do I understand then that  
16 you have taken the charts of a number of infants  
17 who were patients at the hospital, you have collected  
18 certain information from those charts and you have  
19 in effect fed that into a computer?

20 A. Yes, that is right.

21 Q. That is what you call the data  
22 base, is it?

23 A. Yes.

24 Q. So somewhere there is a computer  
25 with an accumulation of knowledge that you have put  
into it?







1

2

A. Yes.

3

4

Q. And from that computer it is possible for you to pull out certain information on request?

5

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A. Yes, information relating to all or any of the persons who are in it, but besides the 46 babies there is a controlled group of living babies who are in the computer as well, and simply the names, dates and times of death of other children at other periods.

11

Q. Where is this computer?

12

A. 25 Grosvenor Street.

13

Q. Are those your offices?

14

15

A. No, it is some government computing - I mean, I have never been there, but it is the Government Ministry computer.

16

17

18

19

Q. And as to some of the children at least I gather there is fairly detailed information that you have put into the computer, for example, medication they were on, that type of thing?

20

A. Yes.

21

Q. Symptoms that they exhibits, would they be on as well?

22

23

A. Not necessarily, no.

24

Q. The condition that they were

25





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being treated for is that on?

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A. Well, this is purely factual, some of the things you are asking me I think would have to be interpreted by a doctor. All I could code, this is in code, and all I can code in input must be clearly factual and not interpretive.

8

9

Q. Do you have some sort of code or listing that will show us the categories that you have actually fed into the computer?

10

11

A. We have a list of codes that is several months old, or more.

12

13

14

Q. That would at least tell us the type of information that you have extracted from the charts to put into the computer?

15

16

A. Yes, it might, though not everything is decoded, so the codes only list items that are decoded.

17

18

Q. What do you mean decoded?

19

20

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A. We have a translation from the code, the code for Aspirin might be ASP, where we might have a translation which will write Aspirin instead of ASP to help people who don't know the code, but not every item is decoded, so the coding list does not include items that are not decoded, such as room numbers.





1  
2  
3 Q. So room number would just go  
4 in as 418?

5 A. Yes, it goes in as 418, or  
6 431, or 423 and comes out in the same form.

7 MR. STRATHY: Mr. Commissioner, I  
8 don't want to take up a great deal of time with  
9 the witness but I wonder if these codes would be  
10 available to us that we could see them and review  
11 them. Further, if need be, whether we could have  
12 access to the computer ourselves.

13 MR. LAMEK: If I may respond to  
14 that, Mr. Commissioner, I am prepared to give no  
15 such undertaking at this time.

16 MR. SCOTT: Well, it is rather  
17 out of turn, but perhaps since we are dealing with  
18 it now, if my friend will permit me to raise it.  
19 I don't want access to the computer and would not  
20 know what to do with it if confronted by it.

21 Surely it is within the realm of  
22 possibility that Mr. Lamek can produce for us, in  
23 sufficient detail, the coded or uncoded so we can  
24 understand it, the kind of factual information that  
25 it is on the computer so we will have ---

THE COMMISSIONER: What good will that  
do?





1  
2  
3 MR. SCOTT: That will at least tell  
4 us what is available on a computerized basis? Then  
5 if we should persuade you that it is desirable to  
6 run off, to push the computer button that will tell  
7 us how many babies had Aspirin in an eight-month  
8 period or something, then we will have to ask you  
9 to consider whether that should be done. None of  
10 that can be done until we know, as I understand it,  
11 what information is fed into the computer, what  
12 catalogue of goods is there.

13 THE COMMISSIONER: Are you not a  
14 little premature with this in any event?

15 MR. SCOTT: Well, I am not premature,  
16 I think in the sense that all I want Mr. Lamek to do  
17 is at some early stage let us know what the capacity  
18 of the computer is.

19 THE COMMISSIONER: Well ---

20 MR. SCOTT: And if he can do that  
21 then we shouldn't have the right to operate it,  
22 it is not our computer, but we can then ask you in  
23 an appropriate case whether you would press the  
24 button for us.

25 THE WITNESS: I would like to  
interject as the author of this thing, that it was  
designed to be used on an on-line basis, which means







1  
2 that every request anyone has has to be made by me  
3 separately with a little mini-program written to  
4 get it. So it is not the easiest thing in the  
5 world, believe me it is exceedingly difficult to  
6 consult for a number of people.

7 THE COMMISSIONER: Well, pressing  
8 a button in any event ---

9 MR. SCOTT: Let me just add, there  
10 may be that problem about getting access, but you,  
11 Mr. Commissioner, will be a good sieve to see that  
12 we don't make requests that are unreasonable. If  
13 I fail I am going to ask the witness to do a computer  
on the Court of Appeal.

14 THE COMMISSIONER: Very appropriate.  
15 Can we not think about this for a while. It doesn't  
16 seem to have anything to do with the charts that  
have been produced so far.

17 MR. LAMEK: That I think was my  
18 point, Mr. Commissioner. I was careful to say that  
19 I am not prepared to give any undertaking at this  
20 time.

21 THE COMMISSIONER: I think the thing  
22 to do is to think about it. I have no doubt  
23 Mr. Strathy and Mr. Scott will not let it drop and will  
24 bring it up at some other time after the thought  
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process and after some discussion with Dr. Bryson  
has taken place.

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MR. LAMEK: I share your confidence  
in that, Mr. Commissioner. Let me say only this,  
the thought has been given already to the extent  
to which computer generated information may be  
possibly made available to other counsel, it is  
not a thing which has been dismissed already.

10

11

THE COMMISSIONER: No.

MR. LAMEK: And as soon as we have  
a position on it I will let everybody know, sir.

12

13

THE COMMISSIONER: All right.

14

15

MR. BOGART: If I could just interject,  
I would add the same interest that Mr. Scott and  
Mr. Strathy have.

16

17

THE COMMISSIONER: Yes. Mr. Strathy,  
are you content for the moment to let the matter lie?

18

19

MR. STRATHY: Well, as I understand  
it, Mr. Lamek is going to consider his position  
and let us know.

20

21

THE COMMISSIONER: That is right.

22

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MR. STRATHY: I think, Mr. Commissioner,  
there is one point that needs to be made. I know  
that Mr. Lamek for reasons of his own, in many cases  
has decided to split the evidence of various witnesses,





1  
2 and I think we are going to try and go along with  
3 that as far as possible. There obviously comes a time  
4 when it is not appropriate for other counsel to  
5 go fully along with that split and this may be one  
6 of those times.

7 THE COMMISSIONER: This, of course,  
8 is one of the things, you will excuse me, but right  
9 at the moment you don't know. I don't know whether  
10 any thought might be given perhaps to a session  
11 with Dr. Bryson and counsel so that the fishing  
12 questions we can dispose of. Have you given any  
13 thought to that?

14 MR. LAMEK: Mr. Commissioner, I  
15 had not, because I confess, perhaps in a simple-  
16 minded way, that questions of interpretation and  
17 certainly questions of other kinds of work done at  
18 different places for different people would not be  
19 appropriate at this stage. I confess I still don't  
20 see the necessity to encroach into those areas at  
21 this time. If Mr. Strathy can persuade me of it  
22 privately that may be something different.

23 THE COMMISSIONER: It is something  
24 we can think about. Frankly I am not at all moved  
25 that this has relevance to this particular issue.  
It may well have relevance and it well may be, I





1  
2  
3 don't say entitled to it, but it may well be of  
4 assistance to the Commission, to you and everybody  
5 else if we do have it later on. We are going to  
6 think about that.

7 MR. STRATHY: I won't pursue it  
8 further at this time. Except I think I should say,  
9 Mr. Commissioner, that it seems to me with respect  
10 that it does have relevance. This doctor has  
11 prepared a detailed, as I gather, analysis of the  
12 various charts of the number of the children that  
13 we are concerned with during this phase of the  
14 Inquiry and to know exactly what she has done and  
15 the material that is available.

16 THE COMMISSIONER: As I understand  
17 it, and I may be quite wrong, but as I understand it  
18 all she has done is taken facts, facts which are  
19 found in various documents put before her and put  
20 it on the computer. She may or may not have, the  
21 computer may or may not have produced some results  
22 for her. Surely the facts are all available. I  
23 don't understand computers and I never have. They  
24 were invented long after I was invented, so they  
25 are quite beyond me, except I understand they come  
up with answers that might take us a little longer  
to come up with.







1  
2 At any rate I don't want to explore  
3 the problem here and now. Maybe you will have a  
4 session exploring it with Mr. Lamek and Dr. Bryson.

5 MR. STRATHY: If I can cast my  
6 fishing rod one last time, Mr. Commissioner.

7 THE COMMISSIONER: All right.

8 MR. STRATHY: Q. Doctor, in the  
9 course of the work that you have done, have you  
10 put together some type of profile for each child  
11 that lists the salient data that you were concerned  
12 about?

13 A. No, no. I have done very  
14 little analytical data.

15 Q. You have simply taken the  
16 materials from the chart, using the code?

17 A. I have the material, yes, from  
18 the charts coded and put in and then brought back  
19 according to what I was asked to produce.

20 Q. Dealing specifically with the  
21 information produced today. You have produced a  
22 chart, which is Exhibit 35, a coloured chart,  
23 showing the various times of death during the  
24 different periods. You mentioned that what you  
25 looked at was in fact the time of death rather than  
what one might call the time the child first showed  
signs of distress, am I right in that?

A. Yes, you are correct.

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Q. And that in fact, am I right that some of the charts do in fact indicate that the child began a period of distress at a certain time and subsequently there was death?

A. Definitely.

Q. And I take it nor have you shown the time when what is referred to as a Code 25 was called?

A. I have that information, but not here with me.

Q. And, again, that in many cases would obviously differ from the time of death?

A. Not by a very great deal, no, in the vast majority of cases.

Q. Well, in some cases, would it be as much as 40 minutes to an hour?

A. Oh, definitely, definitely.

Q. I take it even longer in some cases?

A. Enough to go back into another time period would be exceedingly, exceedingly rare in this case..

Q. All right. But there would be some obviously where, if you take the time the Code 25 was called, it might alter the time period?

A. Very, very rarely.





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Q. We would have to check the records, I guess, to see when?

3

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A. Yes.

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Q. All right. The time of death, and maybe you don't know enough medical information to be able to tell us this, but the time of death shown on the chart, would that in some cases simply be when resuscitation efforts were ceased?

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A. Well, as far as going by the nurse's note, they frequently mentioned the two events: resuscitation ceased and baby pronounced dead at a certain time. I take the pronounced dead at a certain time as being the most probable time at which the baby died, which usually varies by about one minute from the other time.

16

17

Q. From the time of resuscitation ceasing?

18

19

A. Yes. Sometimes a variance of one minute, maybe more.

20

21

22

Q. Are you able to assist us at all, and I suppose the answer is no, but whether the child was in effect clinically dead prior to being pronounced dead?

23

24

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A. I am not qualified to discuss that.





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Q. The data that you have put together for the time of deaths, times of death, is that available? Some were in written form, the actual times for the individual children?

A. Well, I have it, yes.

MR. STRATHY: I am going to ask, Mr. Commissioner, that that be made available.

THE WITNESS: But I know that you realize there is a great deal of difference on time of death and I don't know whether you want me to release this one set of times.

THE COMMISSIONER: Which time, is it for each child?

MR. STRATHY: The Doctor has indicated that she has the actual times that she used to prepare the chart, Exhibit 35, and to prepare Exhibit 35-A.

THE COMMISSIONER: Well, I think she said that she got it from different sources. Where she had a choice, she chose always what the nurse and doctor said at the end.

MR. STRATHY: But eventually she came down to specific times and it's those specific times that I would like to have.

THE COMMISSIONER: Just the times?

MR. STRATHY: Just the times.







1  
2 THE WITNESS: The names and the times?

3 MR. STRATHY: The names and the times,  
4 which would presumably be like 35-A, except much more  
5 specific.

6 THE COMMISSIONER: Yes. Do you have  
7 that?

8 THE WITNESS: I haven't it with me.  
9 I mean, I have it with me on separate sheets but we can  
10 provide it.

11 THE COMMISSIONER: It could be produced?

12 THE WITNESS: Yes, certainly.

13 MR. STRATHY: I would ask for that,  
14 then.

15 THE COMMISSIONER: That isn't in the --  
16 that is not the same as the Statement of Facts, I take  
17 it.

18 THE WITNESS: No, there are slight  
19 differences.

20 THE COMMISSIONER: All right.

21 MR. STRATHY: Could we make that  
22 35-B when it is produced?

23 THE COMMISSIONER: I wonder, I just  
24 don't want to make life any more difficult, Dr.  
25 Gilmour-Bryson, but could you also put a column as to  
the source, could that be done?





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THE WITNESS: Certainly, sir.

3

Certainly.

4

THE COMMISSIONER: All right. Well,

5

could you do that as well?

6

THE WITNESS: Yes.

7

THE COMMISSIONER: All right.

8

THE WITNESS: By all means.

9

THE COMMISSIONER: I am thinking of that

10

as to whether you got it from, for instance, you got it  
from the autopsy report or you got it from the...

11

THE WITNESS: Definitely, yes.

12

THE COMMISSIONER: Yes, all right,

13

thank you.

14

THE WITNESS: Certainly. Excuse me,

15

this is just for the on ward deaths you are asking  
for this, I presume?

16

MR. STRATHY: Yes.

17

THE WITNESS: Thank you.

18

MR. STRATHY: Q. You mentioned that

19

in the course of telling us about what data you had  
used, you had mentioned that one chart had been  
misaid.

21

A. Yes.

22

Q. Do you know which chart that

23

was?

24

25





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A. Yes, Michelle Deyarmond,

3

a death of no particular significance at all. And the

4

chart I have seen, the C.D.C. has seen it and I am

5

sure it will recur.

6

Q. Who has seen it?

7

A. The Centers for Disease Control,

8

it went back and forth between us. But it is not a  
death on the ward, in any event.

9

Q. All right. You've told us about

10

a number of things that you have done in the course of

11

your investigation. What I would like to know at this

12

point is who set the parameters of what you did.

13

Who was it that decided what types of things you would

14

investigate? Was it you or the Attorney General's  
department?

15

A. But are you now returning

16

to the period of my being with the Attorney General,

17

or are you talking about this material?

18

Q. I'm sorry, in the period that

19

you were with the Attorney General, let us start with

20

that. Who actually set the parameters?

21

A. It was agreed to between me

22

and the Crown and, therefore, I suppose by implica-

23

tion the Attorney General and the needs of the police

24

investigators. It was a communal effort.

25





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Q. Well, just so that I am certain

3

then. What you have shown us these three exhibits,

4

33, 34 and 35, the graphs that you have prepared,

5

were these prepared by you, or the information put

6

together by you before being retained by this

7

Commission?

8

A. Not in this form

9

because, as I believe Mr. Lamek brought forth, I have

10

reviewed it all since then and found certain things

11

which needed to be changed, added some children,

12

removed some others. What you are seeing here comes

13

entirely out of work I've done since I have been

retained by this Commission.

14

Q. All right, let me put my

15

question in relation to that. Who was it that set

16

the parameters of the investigation that you did for

17

the Commission? Was it you or was it Commission

counsel?

18

A. Commission counsel under their

19

direction.

20

Q. And does that apply to the

21

five time periods that you've chosen, beginning in

January 1st, 1979?

22

A. Yes.

23

Q. Was it Commission counsel that

24

25







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set those time periods?

3

A. Yes, it was.

4

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Q. Can you tell me, please, what was the purpose -- the Commission is only charged with looking at the one particular time period, number 3. Can you tell us what was the purpose of including those other four periods?

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A. Well, I do not see how --

THE COMMISSIONER: I don't think you need to answer that question. Isn't it obvious? Perhaps the things that are unobvious to me are obvious to others and things that are obvious to me are unobvious to others. But surely the number of deaths means nothing at all, unless it is compared with other periods.

MR. STRATHY: Well, that, I suppose sometimes it helps to have the witness say the obvious.

Q. Is that so, Doctor?  
Is that what it was for, comparison?

A. Yes.

THE COMMISSIONER: But how would the witness even know? Presumably, this is Mr. Lamek's devious mind that this whole thing was generated.

MR. STRATHY: I see.





1

2

Q. Well, did you have any input,  
Doctor, in choosing these separate periods?

4

A. No, I did not; no, I did  
not.

5

6

Q. So, you were just asked to  
put together the information?

7

A. Yes.

8

9

Q. And do you take it, or did you  
take it at the time it was for purposes of comparison?

10

A. Yes, I certainly did.

11

12

Q. And is there any reason, other  
than the fact that you were told not to, why you didn't  
go back before 1979?

13

14

A. I have no data prior to 1979.  
I would be delighted, should Mr. Lamek wish me to do  
so, to go back as far as anyone wants and as  
far as the Hospital records can supply the informa-  
tion, but I was not asked to go back further than  
that.

15

16

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18

19

Q. All right. So, do I take it  
when you say you would be delighted that at least it  
would provide you with more to compare the particular  
period with?

20

21

22

A. I am not sure that I think it  
would be appropriate to go back further.

23

24

Q. Why do you say that?

25





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A. Because we are at a much greater distance from 4-A and 4-B and the period that we're talking about.

3

4

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Q. Well, we are in a period where at least there was a 5-A, wasn't there?

6

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11

A. Yes. But we can go back but we can't go forward, you see, because, unless you are going to wait for a year. If you want to wait for a year, then I will go back a year and forward a year, but we can't keep it equal if we go back to five.

12

13

THE COMMISSIONER: Please, don't give anybody that idea.

14

15

THE WITNESS: Oh, I'm sorry, sir, I'm sorry.

16

17

MR. STRATHY: Don't make any offers at this stage.

18

19

Q. But would I not be correct that you could go back to January, 1979 when there was a 5-A?

20

A. Certainly.

21

Q. And you could do exactly the same sort of analysis as you have here?

22

23

A. Absolutely.

24

25

Q. And that would presumably





11 1 provides you with that much more to compare?

2 A. Yes, it would.

3 Q. When you were given this re-  
4 tainer by the Commission, do I understand that you  
5 were basically charged with finding facts rather than  
6 interpreting?

7 A. I think it would be correct to  
8 say that, yes.

9 Q. So, it was your duty and your  
10 responsibility to put together the raw data, but you  
11 were not, as we haven't heard you here this morning,  
12 at least, to interpret the data?

13 A. No, I'm not qualified to  
14 interpret most of this data.

15 Q. Right. Thank you. Now, dealing  
16 with the periods that you did look at, I'm going back  
17 to Exhibit 35, one thing that I don't quite understand--  
do you have that in front of you?

18 A. Are you looking at the colored  
19 chart?

20 Q. Yes, I am sorry.

21 A. Yes.

22 Q. Exhibit 35 is what it is now?

23 A. Yes.

24 Q. It's entitled "On-Ward Deaths  
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by Time"?

A. Yes.

THE COMMISSIONER: Has Dr. Gilmour-Bryson got it?

THE WITNESS: I have a copy, sir, thank you.

THE COMMISSIONER: All right.

MR. STRATHY: Q. What I particularly didn't understand is why you chose the hour of 0100 to 0101 to commence your period, rather than what would appear to me to be a logical start at 0000.

A. I also prepared another chart at 0000 and went to 4 a.m. and I have another chart that goes from 0 to 6 and I think that's a very good question. The reason why I chose this one is that this is the smallest time frame in which the largest number of deaths occurred. We have the charts here. If you take the 0000 to 0400 then you are splitting the number of deaths in two because they happen to be right in between 3 and 5 a.m. for the most part.

Q. So, what we have here, by picking this particular period is, you have -- your column is that much larger?

A. Well, you will see in a second the column for the 0 to 6 is very, there is very little





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difference in the 0 to 6, it is the 0 to 4 which  
gives you...

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Q. Well, let's look.

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A. First the 0 to 4. James, if  
you don't mind. This is the 0 to 4 and because of  
the death, incidence of death between 4 and 5, the  
column gets divided in two.

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And then we have another one  
for 0 to 6.

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Q. Perhaps if your associate can  
just sit down for a second. Thank you.

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And the result of shifting the periods  
around is that the deaths, instead of being -- how many?

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A. 24, I believe.

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Q. 24 in the 0101 to 0500, we now  
have in the midnight to 4:00 we have 15?

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A. Yes.

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Q. And in 4:00 to 8 a.m. we have  
12?

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A. Something like that, yes.  
Because you are spreading it out over eight hours  
instead of four.

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Q. So, in effect, what Exhibit 35  
does is by shifting the periods at least in a sense  
artificially increases the size of the column?

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A. It does not artificially increase it, at all.

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Q. I'm sorry, it increases the size of the column, depending on what time period you are looking at?

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A. Since the time period is the same for all five groups, then it seems to be eminently fair. If I were to apply different time periods to different groups, then, of course, it would be unfair.

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Q. All right. Well, let's mark this chart, then, the next exhibit.

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MR. LAMEK: Exhibit 36.

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THE COMMISSIONER: I wonder if we could make that one, so that we would be able to make it -- could we make that 35-A?

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MR. STRATHY: I think we have a 35-A and a 35-B now, maybe 35-C. I don't mind if it's made 35-A and we could renumber the other one.

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THE COMMISSIONER: Oh, no, no, no. Perhaps, whichever you like, I just thought it would be easier.

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MR. STRATHY: Well, I would suggest making it 35-C, then, if that's okay.

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THE COMMISSIONER: No, wait a minute.

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This is a new chart, no, I'm sorry. It is quite different because it is different times. So, let's give it a different number. That will be 36.

---EXHIBIT 36: Chart entitled "On-Ward Deaths,  
0001 - 0005."







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THE COMMISSIONER: Those are the times, so we can have it, 0001 to 0400 and four hour periods thereafter.

Yes, all right.

MR. STRATHY: Q. Now, I wonder if my friend Mr. Lamek in his usual way could make copies of that available if the doctor could assist in reproducing - if that can be reproduced.

MR. LAMEK: Yes.

MR. STRATHY: Thank you.

Q. Could you look at the next chart, please, the six-hour segment.

What this does, Doctor, I think as you pointed out, it combines the figures that we have already seen from the previous two bar charts.

A. All three of them really are showing you the same figures broken into different time period.

Q. But the periods that we have just looked at on Exhibit 35, that is the 0101 to 0500 and on Exhibit 35Z or whatever it now is, midnight to 4:00 a.m. are now included in that one large column.

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A. Well, they are not all included because 0 to 8 is eight hours and 0 to 6 is six hours, so some of them are included and some are not. Necessarily.

THE COMMISSIONER: Sorry. Surely all the deaths from 0101 to 0500 are all included in 0001 to 0600?

THE WITNESS: Yes, they are.

MR. STRATHY: Q. That is all I meant.

A. Yes. Yes, certainly.

MR. STRATHY: Yes. Thank you. If that could be the next exhibit then?

THE COMMISSIONER: Exhibit 37.

--- EXHIBIT NO. 37: On-ward deaths by time  
(six hour periods).

MR. STRATHY: Q. And while we have the projector on, Mr. Bogart in his cross-examination asked you to identify some other charts which you have done. I am afraid I didn't quite understand them.

Can those be put forward again?

A. I would certainly like to - if you are going to get copies of those I would like to review them because those were made late at night on the kitchen table and we didn't really think that we were going to show them.

THE COMMISSIONER: Was that between 0100 and --





G.2

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THE WITNESS: No, between 2400 and 0100.

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MR. STRATHY: Well, I certainly don't object to them going in in the form that they are in once you have satisfied yourself that they are accurate.

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THE WITNESS: Yes. I would prefer for my own sake to make sure that I did it right.

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THE COMMISSIONER: All right.

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THE WITNESS: This is just that small number of Ward ICU deaths if looked at by time, but the number is so small that I personally don't see the relevance of that.

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MR. STRATHY: Q. Yes. All right, just so that I understand what they are. Are these deaths that occurred in the ICU coming from the ward?

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A. That is right. Not coming from the operating room. It was a total of 13 --

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Q. That is coming from --

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A. -- or 14.

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Q. And that is coming from 4A and 4B?

A. Or 5A if we are talking about Period 1. This is putting periods together.

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Q. And does this take all the periods, all five periods then?

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A. I can't remember what it has got in it, but I can figure it out for you.





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It says all periods, but I would have to find the equivalent piece of paper from which it was made, which I have I am afraid not with me.

Q. All right. So it shows then there was a total of 14 deaths from the ward to the ICU?

A. Yes, that is correct. So that is all five periods because it is 3, 3, 3 and 2. So is all five periods.

Q. And, for example, four of those deaths occurred in the period from 5 a.m. to 9 a.m.?

A. That is right, yes.

MR. STRATHY: Thank you. If that could be an exhibit then?

MR. LAMEK: Subject to it being checked. If that could be an exhibit.

THE COMMISSIONER: Deaths in the ICU coming from the Ward.

THE WITNESS: Total of 14 deaths only.

THE COMMISSIONER: As to time period?

THE WITNESS: Yes.

THE COMMISSIONER: Time of death subject to review ...

--- EXHIBIT NO. 38: Document entitled: Ward - ICU Deaths By Time. All Periods.







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MR. STRATHY: Q. Now you have shown on the next chart - it is entitled "Total Deaths by Time Periods 1, 2, 4 and 5 --

A. This is omitting Period 3.

Q. And do you know offhand what the total number of deaths were?

A. Well, I suspect that it is --

Q. It looks like 109. Mr. Lamek agrees it is 109.

A. 109. Yes, that comes to the total, so that is the total number of all types of death omitting Period 3 by time.

Q. All right. And just to take an example there then in the 1 p.m. to 5 p.m. period there were 26 deaths?

A. Correct.

Q. And I take it that because you have told us you weren't called upon to interpret you don't have any particular interpretation as to why there would be 26 deaths occurring in that period and only 12 in the 5 a.m. to 9 a.m. period?

A. Well, I think even an historian would be able to say that since we are including the operating room deaths in here and the operating room ICU deaths, common sense unfortunately places those





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events frequently in the late hours of the afternoon.

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Q. So you would attribute that

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increase then presumably in that period and the

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subsequent periods to operating room deaths?

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A. Well, yes, I have plotted a

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different time - the time frame of operating room  
deaths naturally differs, of course, from others.

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Q. But is that the interpretation

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you give then to those 66 deaths occurring in the

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hours from one o'clock to --

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A. 26, sir.

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Q. No, I am sorry. I am adding 26,

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20 and 20.

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A. I have no substantive inter-

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pretation to make of those figures. I am just looking  
at patterns.

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Q. Well, I am sorry, I understood

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that you had looked at patterns.

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A. I have looked at patterns, yes.

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I am showing you patterns, and I am sure the Hospital  
will be able to interpret what the patterns mean.

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Q. I take it that is something

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you would rather not --

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A. Yes, I don't think my opinion

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as an historian as to why deaths would occur at a

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certain time, I don't think that is proper.

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MR. STRATHY: All right, thank you.

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THE COMMISSIONER: We haven't made that  
an exhibit yet?

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MR. STRATHY: Excuse me. Could that  
be the next exhibit then?

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THE COMMISSIONER: Exhibit 39.

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--- EXHIBIT NO. 39: Document, Total Deaths By  
Time Period.

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MR. STRATHY: Q. Did you, Doctor, look  
during any of the five periods you mentioned at total  
hospital deaths?

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A. No. No, I did not.

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Q. Is that simply because you were  
not asked to do that?

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A. Yes. I was not asked to do that,  
no.

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Q. What about deaths associated  
with wards other than Wards 5A and 4A and 4B?

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A. I have certain information on  
some deaths from 7G but I was not asked to do a complete  
job on 7G so I have not done so.

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Q. With respect to timing shown in  
Exhibit 35, did you look at timing of deaths for any  
other wards than 5A and --

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A. No, I have not looked at any other wards at all.

Q. Is that for the same reason, because you were not asked?

A. Yes, because I was not asked to.

Q. You have mentioned at least one factor in relation I think to Period 3. I will put Exhibit 34 in front of you. That is the form entitled "On Ward Deaths by Period", and as you mentioned both in chief and in your evidence when you were asked by Mr. Bogart during that period apparently there were four new infant beds or an increase in four infant beds over what existed in 5A?

A. Yes.

Q. So that there were 32 beds in total in 4A and 4B whereas there would only be 28 in 5A?

A. So I understand, yes.

Q. And specifically those were infant beds rather than beds for older children?

A. From my understanding, yes.

Q. Do you know, is an infant bed a crib or is it a bed for a child of two or so?

A. We would have to ask the Hospital how they qualify an infant bed whether it is up to 18 months or 12 months or 2 years, I don't know.







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Q. Perhaps you can help me, and I am sure this won't account for all the difference, but might this be something that might account for an increased number of deaths in that Period 3 as opposed to Periods 1 and 2, for example?

A. I think it is possible, but don't forget those beds were also there for Periods 4 and 5.

Q. Yes, quite so.

A. They were there for 3-1/2 of the 5 periods, but I think the Hospital I am sure will answer that question for us.

Q. All right. In the periods that we are looking at, did you make any study of the population of the ward during the material times? That is, how many babies were on the ward during these time periods?

A. I only have fragmentary information on spotchecking months of different years of population, but I understand those figures are available elsewhere.

Q. Presumably that would be something that would assist us or whoever was about to do it in terms of interpreting this data?

A. Definitely.





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Q. You would want to know the  
number of deaths in relation to total population?

A. Certainly.

Q. What you are telling us I guess  
is that that information is available somewhere?

A. Yes.

THE COMMISSIONER: Somewhere, Mr. Strathy,  
we are going to take that break. Is this convenient?

MR. STRATHY: Well, I can be two more  
minutes or I can stop now. Maybe to stop now would be  
best and then I can check my notes.

THE COMMISSIONER: Yes. All right.  
Fine. We will rise for 15 minutes.

--- Short recess.





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---Upon resuming at 11:50 a.m.

THE COMMISSIONER: Yes, Mr. Strathy.

MR. STRATHY: Q. Doctor, if you could take Exhibit 33 which is your Total Death by Period chart. In the course of your evidence where you broke down those deaths, you indicated that there were four - I'm sorry, let me be a little more specific, dealing with period No. 2, that is 22 in total?

A. Yes.

Q. You indicated that four of those children died in the operating room, nine died in the Intensive Care Unit having come from the operating room, and three died in the Intensive Care Unit having come from the ward, and six died on the ward. Now, I believe you indicated at the time that one of the figures or perhaps all of them were unusually low and you mentioned you would be saying more about that later, but I am not sure you did say more about that later.

A. I just felt that I ought to point out, because it was pointed out to me by the Hospital, that the death rate in Period 2 was unusually low, but I am sure the Hospital for Sick Children will be discussing that.





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THE COMMISSIONER: It is just in the Intensive Care Unit from the operating room I think it is lower.

THE WITNESS: Yes. The operating rate, the Hospital perhaps can answer that, it is lower than usual.

MR. STRATHY: Q. Well, that is what I wanted to be clear about, were you saying it was that figure, the nine who died in the Intensive Care Unit from the operating room that was low, or was it the ---

A. Yes, that is what affects the total, that is what affects the total because the other figures are more or less average for the period.

Q. So that there is no, the figure that makes that unusually low then is that nine from the Intensive Care Unit?

A. Yes.

Q. It has the effect of ---

A. It is the operating total of 13 I believe it was versus an operating total of 22, 28, 24 and 18. When we are dealing with very small numbers, even a difference of five, is rather large.

Q. I am sorry, that operating







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total of 13 you gave us was 13 operations during  
the period?

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A. Oh no, I have no idea how  
many operations were done during the period. Deaths,  
deaths occurring either in the operating room or  
in the ICU from the operating room. I have no idea  
how many operations were performed.

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Q. I see, so that 13 you gave us  
was the total of 9 and 4 then?

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A. Yes, that's right.

Q. But what you are saying, as I  
understand it, you don't know at this point why it  
is that that figure is unusually low?

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A. No, I do not. The reason for  
that would have to be expressed by the hospital I  
think.

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Q. In any event whatever the  
reason the ultimate effect is to make the total  
number of deaths in that period less than what  
appears to be the norm for the other periods?

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A. Yes, there is a remarkable  
consistency in the other three periods of totals.

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Q. Dealing finally with the things  
that might affect the columns that we see there. I  
take it obviously one of the things that would affect





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the size of the column would be the relative health or illness of the children on the wards during the individual periods.

A. Certainly.

Q. And that would be something that you would not have interpreted?

A. No.

Q. But the hospital might be able to assist us on that?

A. That is right, I am sure he could.

MR. STRATHY: Thank you. Those are all my questions.

THE COMMISSIONER: Thank you.  
Miss Cecchetto?

CROSS-EXAMINATION BY MS. CECCHETTO:

Q. Dr. Bryson, you have been asked about your involvement with the Attorney-General's Office. Am I correct when I say that your involvement extended from July 5th, 1982 to approximately December 7th of 1982?

A. That is correct.

Q. You have also been asked about your mandate with respect to the Attorney-General's Office, and with respect to this Commission. Could





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I ask you whether you were ever directed to present the data in such a way as to reflect a particular point of view?

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A. Absolutely not.

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Q. If we can turn to Chart No. 1 please, Exhibit 33, that is on the screen right now. Doctor, you indicated the number of 64 represented the operating deaths?

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A. No. Excuse me, 64 represents the total deaths not the operating deaths.

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Q. Well, it represents a breakdown of the operation deaths, Intensive Care Unit deaths and the ward deaths?

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A. Correct.

Q. And with respect to Period 4, perhaps I have taken the figures down wrong. could you give me the breakdown?

A. In Period 4?

Q. Yes.

A. In Period 4, five in the operating room, 19 in the ICU from the operating room, for 24. On the ward, I have to look at my other chart here, one and three I believe from - yes, three from the ward to the ICU.

Q. When I add that up I get a





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total of 28 as opposed to 29.

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A. 28 is the correct figure.

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Q. 28?

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A. That is 28 there.

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MR. LAMEK: No, it is 29.

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THE WITNESS: I am sorry, she is talking about Period 9, let me see again, that would be 3, 27, if you like I will get Period 4, it will be easier than taking it from separate sheets of paper here.

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Period 4, one on the ward, three from the ward to the ICU and the remainder, there is one in the Cardiac Lab, I am not sure where to put him, there is one in the Cardiac Lab.

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MS. CECCHETTO: Q. So that brings the total to 29?

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A. Which I think I am putting with the operating room, it is very difficult to know but the Hospital could advise us on that, whether that one should go as a ward death or an operating death.

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THE COMMISSIONER: Five in the operating room, that is five plus one if you count that ---

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THE WITNESS: Yes, the Cardiac Lab







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is very awkward.

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THE COMMISSIONER: The Cardiac Lab,

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what is that?

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THE WITNESS: Where they do the

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cardiac catheterizations on 4A or 4B.

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THE COMMISSIONER: Would this be on

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the way to or from the operating room?

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THE WITNESS: It would be from the

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ward to the ---

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MR. LAMEK: I don't know whether

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I can help, Mr. Commissioner, Dr. Rowe can tell you

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about this later. As I understand it the cardiac

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catheterization process is an invasive diagnostic

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technique, they look at you from inside as it were

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and it requires surgical consent and all those

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things, it is not the OR.

THE COMMISSIONER: It is not

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part of the Operating Room?

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MR. LAMEK: It is very often a

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diagnostic technique to determine whether surgery

is an appropriate course of treatment.

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THE COMMISSIONER: I thought it would have belonged in the ward but I know nothing about that.

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THE WITNESS: On my summary card

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for that period I have total 29, ward deaths one,

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: Cardiac Lab one, Ward - ICU three, OR, or OR-ICU 24  
and I think we will have to have advice on where we  
put the Cardiac Lab one.

MS. CECCHETTO: Q. Thank you. Now,  
Doctor, could you give us the percentage increase  
between Period 3 and Period 1 for Chart No. 1,  
Exhibit 33?

A. If I have it. I would like to  
warn everybody that percentage increase is a very  
sticky figure, and when you are dealing with small  
numbers you can have a small number change, such as  
from 1 to 2 and a very large percentage increase of  
100 per cent. So I would not wish that anyone would  
take percentage increases by themselves without  
looking at the size of the numbers under discussion.

THE COMMISSIONER: Were you asking  
about the ward deaths or the total deaths?

MS. CECCHETTO: The total deaths  
right now.

THE COMMISSIONER: It is obviously  
a little over 100 per cent, isn't it?

THE WITNESS: Yes. I am just  
looking for the total deaths. Total death average  
of the other three periods is 27.25; the total for  
Period 3 is 64; the numerical increase is 36.75





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which is safer figure really to work with; the percentage increase is 134 and that is .86 if anyone even cares about the decimal place, it is a percentage increase of 135 if you round it off.

MR. CECCHETTO: Q. And Doctor, have you computed the average percentage increase of Period 3 vis-a-vis the other four periods?

A. No. I have taken the other four period averages and applied it to that because I do not really wish to single out any one period, except that we have to by our mandate consider Period 3. Since the numbers are so similar I can of course do it for this afternoon, but I really don't quite see the relevance of computing slightly different percentage increases to other periods

Q. All right. Turning to Chart No. 2 which is "On Ward Deaths by Period", Exhibit 34. That chart indicates that there is 34 deaths during Period No. 3, the relevant period. Doctor, can you indicate if you have a breakdown for the number of deaths that would have occurred in Ward 4A and in Ward 4B?

A. Yes, I can give you that. In Period 3 on Ward 4A there were 76.48 percentage of the on Ward Deaths; and on Ward 4B





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there were 23.52 per cent of the on Ward Deaths.  
There were eight deaths on Ward 4B and eight from  
34 leaving us with 26 deaths on 4A on the ward.

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Q. And Doctor, you have indicated your concern about the percentage increase but could you give us the percentage increase between Period 3 and Period 1?

A. The percentage increase of what?

Q. In the number of deaths by ward, please?

A. Well, if you're looking at the percentage of ward deaths, I still prefer to look at it as, and have computed it as an average of the other groups. If you're going to go from an average of - I'm looking for the right page here - here we are, ward deaths. The average of ward deaths in the other periods is 4.75. In our period we have 34. We therefore have a numerical increase of 29.25 and a percentage increase of 615.78 per cent, if you take Period 3 over the average of the other periods.

If you discount Period 4, and it seems to me fair to look at it also discounting Period 4, which it does not fit into the pattern either, if you compare the Period 3 to the, let us say in quotes "normal periods", 1, 2 and 5, then you're going to see a smaller increase because the average number will be higher.





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MS. CECCHETTO: Thank you, Doctor,  
I have no further questions.

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THE COMMISSIONER: Mr. Roland?

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MR. ROLAND: I have no questions.

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THE COMMISSIONER: Mr. Shinehoft.

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CROSS-EXAMINATION BY MR. SHINEHOFT:

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Q. Doctor, I'm interested in the  
source in which you got your information to compile  
these statistics. Now, you indicated initially that  
you examined some records, is that correct?

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A. Initially I received a list from  
the Hospital for Sick Children with babies names  
and history numbers and dates and so on. I then,  
in some cases, looked at the chart. We are now going  
back to last summer. I received a computer printout  
later from the Hospital with more names and  
history numbers and once again I looked at some of  
the charts, if I had some doubt about where the  
death might have occurred, and recently in the last  
10 days I have looked at all the charts in order  
to attribute the babies correctly to the right place  
of death, date and time. So, these are hospital  
medical charts, hospital death notices and hospital  
lists.

Q. Well, what you have compiled,





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would it not be fair to say would be essentially  
a mortality review that you have done by graph?

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A. No, because I would not be  
competent in any way to do a mortality review.

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I am simply providing, in one case for the use of  
the Attorney-General, or in another case, for this  
Commission, a list of numbers of deaths at different  
periods of time on similar or the same wards.

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Q. Were you at any time provided  
with charts from the Hospital?

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A. Medical charts?

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Q. Medical charts in addition to  
the graphs similar to the type that you have produced  
for us today?

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A. Do you mean, was I given some  
kind of graphic thing like this representing deaths?  
Do you mean that? When I say medical chart I mean  
a child's chart.

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Q. I understand that, Doctor,  
but in addition to that, did you receive any other  
charts or any other graphic material from the  
Hospital?

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A. I did not personally, no.

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Q. Were you advised that such  
material was available?





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A. No, I was not.

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Q. Was there any enquiries made  
by you as to whether mortality tables, rates or  
charts were kept by the Hospital?

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A. I believe that those questions  
were asked by the investigating authorities but I  
cannot speak for them. They were the ones who  
requested information from the Hospital.

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Q. Were you present when these  
discussions took place between the - the specific  
discussions between the investigating authorities  
and the Hospital?

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A. Not on all occasions, no.

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Q. Were you present on some  
occasions?

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A. Yes, certainly.

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Q. And on any of the occasions  
that you were present, was there any discussion  
with the hospital about the statistics that they  
themselves kept as to the deaths?

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A. Well, the Hospital supplied us  
with some - supplied I should say to the investigating  
authorities - with some charts they had made showing  
autopsy rates at various periods of time throughout  
the Hospital and on Wards 4A and 4B. I can remember







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seeing that material at one time.

Q. And were those charts provided to you, Doctor?

A. To me personally?

Q. Yes.

A. They were at my disposition if I cared to look at them, yes.

Q. And did you use those charts in the calculations that you have made today?

A. No, I could not, because they were total figures on autopsies and I was not preparing any statistics on autopsies. I'm talking about deaths and they were talking about autopsies. So, I could not, from what they gave to us, use that in preparing this.

Q. But do I understand you correctly, Doctor, in saying that you are not sure if in fact they kept records of all deaths as opposed to just autopsies?

A. Who?

Q. The Hospital?

A. I have no idea in what manner the Hospital did keep or does keep its deaths.

Q. So, your involvement in terms of the charting and the basis for which you have made





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this statistical data is only from the documents  
and the charts on the various children that were  
given to you by the Hospital?

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A. That's right, names, and names  
which I found on death notices.

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Q. Now, Doctor, you say that you  
feel that you are somewhat unqualified to interpret  
the data as you are not an expert in statistics,  
is that correct?

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A. That's correct.

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Q. But in your preparation of  
these charts, were you in any way surprised when you  
saw the results of these charts?

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A. I would have to say that at  
this time I was not because I had prepared similar  
material last summer. The first time I prepared it,  
last summer, I was surprised by the results, yes.

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Q. And it would appear to you  
in the limited information and knowledge you had on  
this area that it was somewhat statistically out of  
balance to the norm?

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A. I cannot comment on that.

MR. LAMEK: Mr. Commissioner, to  
be fair. Dr. Gilmour-Bryson was asked if she was  
surprised. Surprised may be a reaction that anyone





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may have had no matter how skilled or unskilled he  
may be in statistical analysis. Whether there was  
any statistical significance is not I suggest quite  
appropriate for the witness to comment.

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MR. SHINEHOFT: Q. But you,  
Doctor, have prepared graphs on other types of  
fatalities or deaths before, have you not?

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A. Yes, I have.  
Q. And have you compared the  
charts that you have compiled before to the charts  
that you have compiled for this Commission and the  
Attorney-General? Would there be some similarities  
or would there be some dissimilarities on those  
charts?

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A. When you said prepared before,  
did you mean before I came to the Attorney-General?

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Q. That's right.  
A. I'm afraid I cannot see any  
relative comparison between the death rate of the  
Templars in the 14th Century and this particular  
case.

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Q. So, there is no relevance?

A. The methodology is the same  
but I have never compared it from looking at the  
two charts, no.





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Q. Did you know the capacity of the wards on 5A or 4A and 4B when 5A became 4A and 4B? You said the number of beds were increased.

A. According to what I was told, yes.

Q. But you weren't given any data as to ---

THE COMMISSIONER: 32 and 28.

THE WITNESS: I was told 32 and 28. But since I did not use any figures of that sort in altering these statistics, I didn't use that information.

MR. SHINEHOFT: Q. 32 versus 28. You did not know if they were 100 per cent occupied, 50 per cent occupied or any information of that sort?

A. No, no. It is impossible for a one man team to take on - I did ask for that information but I did not receive it from the Hospital. It is not possible for one person I'm afraid to go through that kind of data.

Q. And although that information might very well be available from the hospital.

A. Yes, indeed.

Q. But you did not have it?







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A. No, they were not able to  
provide it when I asked for it.

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MR. SHINEHOFT: I have no further  
questions, thank you.

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THE COMMISSIONER: All right, thank  
you. Miss Jackman.

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CROSS-EXAMINATION BY MS. JACKMAN:

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Q. Doctor, if I'm right, we've  
got the on ward deaths by time and the Ward ICU  
deaths by time and the total deaths by time excluding  
Period 3. Did you do the OR 2 ICU deaths by time  
and the OR deaths by time?

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A. In my work for this commis-  
sion, no.

Q. So it is just those three  
categories --

A. Yes.

Q. Of the number of them.

A. Excuse me, if I might say one  
thing. They are, of course, included in the total  
deaths.

Q. No, I understand that. But  
you haven't separately broken that down?

A. Yes. I haven't remade those.

Q. Now, Mr. Strathy had asked  
you if you could give him a list of the specific  
times of death with the names, and I believe the  
Commissioner had asked that you also add the source  
of that. I want to understand how you are going to  
get that. Will that be retrieved from the  
computer?

A. No, no, it will not. I have  
gone through all the charts recently and gone over  
that data, and the four or five different times of  
death given for certain children and noted which  
time is given for each child and what is the source of  
each difference in this data.





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That was something I was requested  
to do by one of the Commission counsel.

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Q. Okay. Well, when you were  
doing that, how did you get that information, from  
going back through each chart or from retrieving it  
from the computer?

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A. No, as I have said, from the  
chart, from the medical chart.

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Q. Okay. Well, I don't under-  
stand what the use of the computer is then. Perhaps  
you could tell me.

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If someone were to ask you, for  
instance, to make a list of the dates of admission,  
is that information not in the computer?

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A. I would not wish to provide  
any information only from the computer without re-  
checking the charts.

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Q. No, but my question is, is  
that information in the computer? I understand you  
would want to check and make sure it is accurate, but  
could you retrieve it from the computer?

A. I would not retrieve it from  
the computer. If you are asking me if I could, yes,  
but I would not. I would take it from the charts.  
Because if you wish to prepare a data base that is





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2 one hundred percent accurate to be used in proceedings  
3 such as these, then it should be prepared by two dif-  
4 ferent people and input by two different people  
5 and run through a collating program and then at the  
6 end of which you recheck all the charts, which we did  
7 not do because we did not intend it to be used in that  
8 way.

8 Q. So --

9 A. For that reason I would go  
10 back to the charts.

11 Q. Okay. So then, Doctor, you  
12 don't make use of the computer at all in any of this  
13 then even though the information is in the computer.

14 A. At times I use the computer,  
15 yes.

16 Q. So when would you use it?

17 A. When would I use the computer?

18 Q. I can't understand why the  
19 information is in the computer if you don't use the  
20 computer.

21 A. Because it was put into the  
22 computer a year ago to assist with the investigation  
23 subsequent to the discharge of Miss Nelles. It wasn't  
24 made to be used here. It was made to help then and  
25 I think it did help.







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It was not to be used subsequently or  
in the future.

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Q. And, Doctor, when you do use  
the computer -- you just said you use it sometimes --  
when do you use it? Now?

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A. If I want to check on some-  
thing or other I use it to get a list of names and  
then go and check them in the charts.

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Q. So what would the something  
or other be? Just give me an example.

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A. Well, I am primarily using  
the computer for another purpose for the Commission  
counsel at the moment. I don't think I have checked  
anything on that data base in six weeks.

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I haven't requested information from  
that data base for several weeks. I am using the  
computer full time now for something else.

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Q. Okay. And it is not the data  
base respecting the children or the deaths?

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A. No.

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MS. JACKMAN: Those are all the  
questions that I have.

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THE COMMISSIONER: Thank you, Ms.  
Jackman.

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Miss Symes?

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CROSS-EXAMINATION BY MS.SYMES:

Q. Dr. Gilmour-Bryson, I wish to ask questions about the data base and its creation. Specifically, the creation of a data base is a very expensive process and a very long process?

A. Yes.

Q. And if you have got existing data base on 46 deaths you are the only person that has it.

A. I am not sure what you mean by "has". Has it in what sense?

It is sitting in the Ministry's computer.

O. All right. It hasn't been destroyed?

A. No.

Q. All right. Are you aware of any other data base, other than the one in the computer?

A. On the same subject?

Q. On the same subject.

A. I am not aware of any. There may be others. I am not aware of them.

THE COMMISSIONER: I am probably the only person in the room that hasn't any idea what you





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mean by a data base.

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MS. SYMES: All right.

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THE COMMISSIONER: Can you help me

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out?

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MS. SYMES: O. Let's start then

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at the very basic: What do you consider a data base  
to be?

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A. I consider a data base to

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be a systematic arrangement of material, usually in  
categories. It can be as simple as a mailing list  
with names and addresses and postal codes., and the  
magazines to whom people subscribe.

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And then if you want, if you are in

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a publishing company and you want to know how many  
clients take Reader's Digest, you punch in Reader's  
Digest, and you will get either a count of the  
people or the list of the people's names.

17

Data bases go from something as simple

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as that to something as complicated as the recent  
census made in China. And it is an arrangement of  
information in precise categories made to enable you  
to sort it, which was my purpose, or to analyze  
it, which was not my purpose.

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O. And do you agree with me that

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it is simply computer jargon for large amounts of

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data, large amounts of information that are stored in a systematic manner such that information can be retrieved from that?

A. Yes, in a specific format, yes.

O. And as you say, it could be as simple as a list?

A. Yes.

O. That is a one-dimensional matrix to a multi-dimensional matrix?

A. Certainly.

O. Now, specifically I see in the copy of the Atlanta Report which was given to me by Commission counsel that the Atlanta Report did a computer analysis of the information?

A. Right.

O. Were you -- did you have any access to the data base they created from this same raw information?

A. No, and I am sure it is an excellent and much wider and fuller data base than my own since it was made by many more people.

O. You had no access to theirs?

A. No, none at all, nor they to mine.







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Q. Now, I want to discuss with you how you dealt with the data base because it may be -- of course, may be that other people would like to have access to the information that is contained therein. Did you enter the information into an existing data base?

A. No.

Q. You, therefore, created your own?

A. Yes.

Q. And I think Mr. Strathy started to ask you this question, but I would like to know what the data base looks like. In other words, what exact information is in the data base for each child?

A. The exact same information isn't in the data base for each child.

Q. Okay. First of all, how many children are in the data base?

A. I cannot tell you the precise number. There is the 46 deaths under investigation. There is approximately 30 in the control group of living babies of which certain aspects are coded and there are approximately one hundred and -- let's say, 100 to be fair -- approximately 100 babies dying





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2 at other times (in other words, not during the  
3 investigative period) who were coded according  
4 to name and time and date of death, probably date of  
5 entry to hospital. Date of birth will give us age.  
6 Date and time of death.

7 Q. Of the 46 deaths that  
8 information has been entered into the data base for  
9 the 46 deaths in question?

10 THE COMMISSIONER: I hope you don't  
11 mean for each one. You don't seriously --

12 MS. SYMES: Mr. Commissioner, what  
13 I expect from my knowledge of the creation of data  
14 bases --

15 THE COMMISSIONER: Yes.

16 MR. SYMES: -- is that there will  
17 be a list of the following information in the fol-  
18 lowing order recorded for each of the children.

19 THE WITNESS: No, I am sorry, there is  
20 not.

21 THE COMMISSIONER: Now, Mr. Lamek, you  
22 want to enter into this?

23 MR. LAMEK: Yes, indeed, Mr.  
24 Commissioner.

25 The last time I suggested we were  
wandering far afield in this morning's evidence you





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1  
2 suggested, and of course I entirely accepted it,  
3 in a general way it might be of some interest.

4 This is becoming really rather a  
5 detailed inquiry as to the construction and format  
6 of a data base. I wonder at what point it becomes  
7 too particular to be appropriate for today.

8 THE COMMISSIONER: Yes. Ms. Symes,  
9 if you can just give me some idea of what you are  
10 trying to prove, what you are trying to find out.

11 MS. SYMES: Absolutely.

12 THE COMMISSIONER: You want to know  
13 everything that is put into a computer. How is that  
14 going to help me in answering the questions that  
15 I hope to --

16 MS. SYMES: For the very reason that  
17 statistical analyses should be done on this data base.  
18 Now, there are two possibilities.

19 THE COMMISSIONER: Now don't -- I am  
20 sorry.

21 MS. SYMES: Mr. Commissioner, just  
22 a second. In a sense of --

23 THE COMMISSIONER: When I was young  
24 we didn't have to have data bases and we didn't have  
25 to have computers in order to work out statistics.

MS. SYMES: Absolutely.





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THE COMMISSIONER: Is that not still valid?

THE WITNESS: It is still valid.

MS. SYMES: It is still valid, but the only caveat to that is that in this particular case the information consists of approximately 200 infants.

THE COMMISSIONER: Yes, I'm sorry, but --

MS. SYMES: And multiple information.

THE COMMISSIONER: And Dr. Bryson has told us she didn't get it from the computer base. She got it from the charts and the information she could get from the charts and various other places. How long is it going to be, but if you are going to ask about every child we will still be here tomorrow morning.

MS. SYMES: Mr. Commissioner, please let me try and finish as to where it is going.

THE COMMISSIONER: Yes, okay.

MS. SYMES: This information that has been entered into the computer is entered in, as this witness said, in a very expensive and very time consuming process.

THE COMMISSIONER: Yes.

MS. SYMES: It is possible for someone







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else wishing to do an analysis of this same information to redo everything that Dr. Gilmour-Bryson has done.

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THE COMMISSIONER: Yes.

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MS. SYMES: To reproduce it. It took her many months to do it. It will take someone else the same length of time to do it.

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THE COMMISSIONER: Yes.

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MS. SYMES: It is surely, since she is now a consultant to the Commission, a reasonable thing that if she created a data base other people may wish access to it to perform statistical techniques in order to know whether or not this data base is valid. That is, has it got the information in it necessary to produce or to do statistical analysis we have to know what is in it. All I want to know is the information which I presume is a list, presumably produced by a computer, of what elements for each of the children have been entered into the computer.

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THE COMMISSIONER: All right.

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MS. SYMES: It may be that the creation of the data base has not been specific enough to do an analysis, but hopefully it has.

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THE COMMISSIONER: Can you tell us --

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THE WITNESS: Yes, let me tell you in general I proceeded in a two stage fashion similar





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to my proceedings of computerizing the Templars  
of the Fourteenth Century.

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The 46 deaths with which we are  
primarily concerned contained a front page of  
data which is potentially possibly open to analysis.

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This page contains the baby's  
sex and code number, the mother's age, if known,  
the father's age, if known, the child's race, if  
known, the date and time of entry to the hospital, the  
date of birth, the date and time of death, the onset  
of critical symptoms, if that is clearly indicated  
in the chart. For some children it is not. Whether  
the child came from out of town or not because we  
have variables in there that we have already decided  
are perhaps not relevant but they were put in  
originally; whether the child was autopsied or  
not, cremated or exhumed or not.

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There are some 20 bits of informa-  
tion on the front page and not all of them can be  
filled in because we do not have the information to  
fill all of them in.

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Subsequent to that, the pages are  
blank in which you fill out the rest of the data  
base. The pages are blank in that there are no codes  
written on them, but the organization of the data is





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2 in eight columns and every item you choose to code  
3 will be accompanied by a code number for the  
4 infant so that you can attach all the information  
5 about that infant to him or her.

6 There will be a date, there will  
7 be two dates in the case of night shift  
8 information. There will be a time. There will be  
9 two times, both time from and time to, in the case  
10 of something entered in the chart such as between  
11 7 p.m. and 11 p.m. the baby had a feeding. You have  
12 to code that as between 7 p.m. and 11 p.m.

13 The central column is a category of  
14 the information and the general categories include  
15 information on feeding, medicine, doctor's  
16 orders, condition of the baby where it was stated in  
17 the chart, diagnosis, if stated, from a doctor and --

18 Q. In order to be able to give  
19 this information to a statistician to see what kind  
20 of analysis could be done, would you produce  
21 a profile of the data base? Could you just tell us  
22 in writing what categories you have done?

23 THE COMMISSIONER: She has already  
24 told you. She has already told you what it is. I  
25 just don't understand --

THE WITNESS: I don't know how to write





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a profile of the data base.

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THE COMMISSIONER: I am getting lost, Ms. Symes. I just don't know what it is. You want this data base and this computer, all of which has nothing whatever to do with Dr. Bryson's evidence. You somehow or other want to have a statistician look through it and see if it was properly kept?

MS. SYMES: No, no, no, Mr. Commissioner. What I want to do is give a profile of the data base to a statistician to see what kind of analysis can be done on the information.

THE COMMISSIONER: That is very much a discovery question, is it not? Do we have to have -- what does it have to do with the charts Dr. Bryson has produced for us?

MS. SYMES: It may give us some answers in less of a crude form.

THE COMMISSIONER: No, but will it tell us that these charts are right or wrong?

MS. SYMES: Obviously the charts are right. That is a simple counting measure, but the question is the other information that we want to be able to factor out in determining what was the cause of death.

THE COMMISSIONER: Well, I don't







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understand. Dr. Bryson is not a doctor, not a medical  
doctor and she can't help us on the cause of death.  
What she can help us on is telling us how many  
children died and when and where and that is what she  
has told us.

MS. SYMES: Mr. Commissioner --

THE COMMISSIONER: Yes.

MS. SYMES: She has also created a  
data base that other people can work on and it is  
that data base that is obviously available and can be  
used by other people to test.

THE COMMISSIONER: Yes. All right.





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A. Not to test whether or not the data base is correct but whether the numbers are correct.

Q. Not to test whether or not the data base is correct, or her numbers are correct, but whether or not there are explanations, statistical explanations for the cause of death which is the very purpose of this Inquiry?

A. But may I say that the CDC data base would be a far superior data base for your purposes, created as it was not only by people experienced in medical statistics but by doctors and this is a full and complete base much more so than my own and would be of far more use for the very interesting suggestion that you have proposed.

Q. Can I ask you again, would you give me a list of the data that you have just by category for each of the 46 infants in question?

A. I can't really, it would take me weeks to do such a thing.

Q. I don't want the actual numbers or coding for each child I want simply your system of category.

A. But my system is not sufficiently systematic to do what you are asking. One child will





K.2

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have lab tests in his file and another will not.

3

One child will have drugs and another will not, and

4

one child may have no drugs and so on, each one is

5

different and I can't give you a list of what is

6

in every one.

7

Q. Just so I understand it,

8

obviously some children receive drugs and other

9

children didn't and that would be fairly reflected

10

in your data base. Or, are you also saying that some

11

children receive drugs that you didn't record in your

12

data base?

A. No, I am not saying that, no.

13

Q. You are saying only the first?

14

A. Yes, but don't forget that for

15

your purposes, which I think are most interesting and  
valuable, you would want to have data on these

16

children for far longer than I have. My data only

17

covers 24 hours prior to death. This is not long

18

enough for what you are suggesting, I am sure a

19

statistician would want far more than 24 hours.

20

Q. What access method do you use

21

to get the data in and out of the computer?

22

A. Well, you can use any kind of

23

terminal you want, you are using the focus data bases,

24

it is running on a focus data bases.

25





K.3

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2

Q. Focus?

3

A. Focus, f-o-c-u-s data base

4

package.

5

Q. And can you tell me if there

6

is a statistical package as part of the focus data  
basis?

7

A. There is, it is absolutely

8

diabolical but there is.

9

Q. Can you tell me if factor

10

analysis is part of your statistical data?

11

A. If what is?

12

Q. If factor analysis --

13

A. I think so, but our data is not

14

structured in such a way that is very amenable to  
this type of procedure.

15

Q. Are you adding to the data base

16

on a continuing basis?

17

A. On occasion, yes, we have

18

decided to add some further information to it.

19

Q. For example, in the last two

20

months have you been adding to the data base?

21

A. Yes.

22

Q. Do you intend to continue to do

so?

23

A. If I am instructed to I will.

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Q. You said you have done no statistical analysis on your data base because you are not a statistician?

A. That is right.

Q. Are you aware whether or not anyone else has done statistical analysis on your data base?

A. Using my data base?

Q. Yes.

A. No, because no one has used my data base except myself.

Q. You are the only person?

A. Yes, that and the police.

Q. Are you aware if anyone from the Attorney General's Department has used your data base for statistical analysis?

A. I cannot answer for the Attorney General's Department, but it is certainly exceedingly unlikely since they don't know how to use it.

MS. SYMES: Those are my questions.  
Thank you.

THE COMMISSIONER: Yes, all right,  
thank you. Mr. Young?

MR. YOUNG: No questions.

THE COMMISSIONER: Mr. Ortved?





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MR. ORTVED: Just a couple of  
questions, Mr. Commissioner.

CROSS-EXAMINATION BY MR. ORTVED:

Q. Is it Dr. Gilmour-Bryson?

A. Yes.

Q. You have obviously been directed  
to utilize nine-month periods for the purpose of your  
analysis, is that correct?

A. That's correct.

Q. And obviously you don't need to  
be anything other than a layman to be able to see  
that that happens to conform to the mandate that his  
Lordship has in terms of conducting the study, correct?

A. Right.

Q. But in fact, I take it you would  
agree with me, that nine-month periods would be an  
unnatural period for the purpose of keeping statistics  
usually?

A. No, I wouldn't say it was  
unnatural. Many statistics are kept on a daily basis,  
weekly, monthly, six-monthly, eighteen-monthly, it  
depends really what you are looking at.

Q. Would you say that annually is  
a common form of keeping statistics?

A. Yes, I would.





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Q In fact you have told us that you are not intimately familiar with statistics kept at the Hospital, but are you able to at least tell us that those were kept on an annual basis?

A No, I am not. I would have to presume they are but I am not in a position to state they are, no.

Q You don't know one way or the other?

A No, I don't.

Q Certainly you will agree with me that if in fact your statistics were collated on an annual basis it would have the effect of flattening the peaks, so to speak, insofar as the numbers you are presenting?

A Definitely.

Q Did you run your collated statistics annually?

A No, I have collated the statistics, because I considered in the period we are dealing with annually has no significance since you are dealing with three months in one year and six months in another but I have done them monthly, broken them down monthly for a three-year period.

Q Right, and are those available?





K-7

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A. No, they are not here, that was

3

done last year, last summer.

4

Q. But you have those?

5

A. Yes.

6

Q. And when you say that really

7

doing it on an annual basis is of no significance here,  
you are really presuming what might be of significance

8

to his Lordship, correct?

9

A. Of course.

10

Q. Because he may find that if in

11

fact statistics were being kept annually at the

12

Hospital that that is something of significance,

13

correct?

14

A. Certainly.

15

Q. For instance, you just happened

16

to make the comment in relation to someone else's

17

questions, that for instance having regard to Exhibit  
34, that Period 4 is really quite unusual?

18

A. Yes, I think so.

19

Q. Right.

20

A. That is because the Hospital

21

pointed that out to me.

22

Q. Right, and if in fact we were

23

keeping statistics on an annual basis of course then

24

the statistics for - and if the statistics were run

25

from January to December then of course the statistics







K-8,

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for the period 1981 would not be so unusual vis-a-vis  
those of 1980?

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A. That is right, they would be  
less unusual.

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Q. And you also make a comment, I  
think it was in answer to a question that Mr. Bogart  
put to you, that really Period 2, and I think you  
made reference there to Exhibit No. 33, was really  
quite unusual in the sense that deaths were lower in  
that period, correct?

10

11

A. The deaths appeared to be lower  
than in the average of the other periods I have before  
me.

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Q. I take it you are aware that  
deaths in the Hospital generally in 1979, which  
happens to include your Period 2, were very unusually  
low?

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A. Well, I find Period 1 to be not  
unusually low, which is, at least all of 1979 is not  
low.

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Q. Well, if I were to suggest to  
you that deaths were approximately 30 per cent lower  
in 1979 at the Hospital for Sick Children by comparison  
to other years, could you dispute that suggestion?

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A. You are talking about overall  
deaths?

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K-9.

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Q. Yes.

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A. In the entire Hospital?

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Q. Yes.

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A. I have no idea what the overall  
death rate was.

6

Q. You didn't look at that?

7

A. No, I did not.

8

Q. It was of no concern to you?

9

A. I was not asked to look into it,  
no, it was of no concern to me, no.

10

11

Q. And so you are not disputing the  
fact that the deaths for 1979 in the Hospital generally  
may be very much off those for 1980?

12

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A. I cannot discuss it because I  
haven't seen the statistics or the proof of the  
statistics, so I can't answer that.

14

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Q. You don't dispute it, right?

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A. I have to dispute it if I haven't  
seen it, I mean, I am just taking your word for it.

18

19

Q. You can't dispute it if you  
haven't seen it?

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MR. LAMEK: Mr. Commissioner, the  
witness' position is clear enough, she can't dispute  
what she doesn't know.

22

23

MR. ORTVED: That's all she has to tell  
me.

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K-10

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MR. LAMEK: Neither can she accept  
what she doesn't know.

4

THE WITNESS: No, that's what I meant,  
I can't accept it because I haven't seen it.

5

6

THE COMMISSIONER: If it is of value  
to anybody, I accept everything that Mr. Ortved has  
said, everything you say and everything that Dr.  
Bryson says, each one of you is stating the truth as  
you see it. All right?

9

10

MR. ORTVED: Q. And something else that  
someone referred to in their questions, Dr. Gilmour-  
Bryson. Do I understand that you did not have any  
regard for cardiac deaths?

11

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A. No, I did not. If by that you  
mean did I add in 1979 and so on?

15

16

17

Q. Yes.

A. No, I was not asked to look into  
that.

18

19

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Q. Presumably those who gave you  
your direction did not consider that of importance, I  
guess?

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A. I presume so.

Q. I take it that you again don't  
need to be, you don't need to necessarily have collated  
those statistics yourself to tell me that those would





K-11

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certainly have a bearing on the peaks that you have  
noted?

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A. I have no idea because I haven't  
seen them. I am only concerned, as was the investi-  
gation and the Attorney General with a particular  
area of the Hospital in a particular period compared  
to the same area in other periods.

8

9

MR. ORTVED: Thank you. Those are my  
questions.

10

THE COMMISSIONER: Miss Solomon?

11

MS. SOLOMON: No questions.

12

THE COMMISSIONER: Mr. Olah?

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MR. OLAH: Thank you, Mr. Commissioner.

CROSS-EXAMINATION BY MR. OLAH:

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Q. I just have a couple of brief  
questions. Do you have Exhibits 33 and 34 before you  
by any chance? 33 is the Total Deaths and 34 is the  
On Ward Deaths?

18

A. Yes, I have that.

19

20

Q. I am wondering, Doctor, did you  
calculate percentages for each time period of on ward  
deaths as compared to total deaths?

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22

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A. Percentages of what? Oh, what  
percentage of deaths occurred --- Would you mind  
asking me that again, I am confused.







K-12

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Q. Well, you have got numbers?

3

A. Yes.

4

Q. For instance, let's take

5

Period 1. Total number of deaths were 30.

6

A. Yes.

7

Q. And Wards 4A, 4B and 5, numbered

5.

8

A. Yes.

9

Q. Did you calculate what percentage

10

that was?

11

A. Oh, I think so, yes.

12

Q. Could you just briefly give it

13

to me?

14

A. Ward deaths? If you hang on

one second I will just try and find the right place.

15

THE COMMISSIONER: What you are asking

16

is what percentage is 5 of 30 and 6 of 32 and 34?

17

MR. OLAH: Yes, it might be simpler

18

to interpret it if we had all the figures.

19

THE WITNESS: I have got 16.66 percentage

20

of ward deaths to total deaths for Period 1, and in  
Period 2, 27.27 per cent.

21

THE COMMISSIONER: How much, 47?

22

THE WITNESS: 27.27 per cent. In

23

Period 3, 53.12 per cent. In Period 4, 3.44 per cent,

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K-13

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and in Period 5 then it's 25.00 per cent. By that I hope I am answering the right question, what percentage of total deaths did ward deaths make up.

Q. All right. Now, we know that Wards 4A and 4B came into being some time in 1980?

A. April the 1st, I believe.

Q. Was it April the 1st?

A. I think so.

Q. That is my recollection also. None of your periods - oh yes, one of your periods does in fact - no, none of your periods commence with April 1st, 1980?

A. No, they don't.

Q. So there is no way of segregating out percentage deaths really for the relevant time parameters except for Periods 4 and 5?

A. No, it could easily be done but it can't be done from what you are looking at.

Q. Now the other area I was interested in as you have told us so much about computers, but we haven't heard very much about your background in computers. We know you are an historian, we know you have a Ph.D. and an M.A., was it?

A. Yes.

Q. Now can you just briefly tell us





K-14

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a little bit about your expertise and how it was  
developed in computers?

3

4

A. In computers, certainly. I

5

started using computers in Montreal while working on  
my Doctorate in 1974 probably, and that was in addition  
of a Latin manuscript, 35 metres of parchment in  
medieval Latin shorthand and ---

6

7

8

Q. Let me just stop you there. Have

9

you had some specific training that you can tell us  
about?

10

11

A. I have published one book on

12

computer applications in the Humanities. I have a  
second book in press on computer applications in the  
Humanities. I gave a lecture at the International  
Conference of Law Logic and Informatics in Florence,  
Italy on Computers in Law, and I am about to begin  
this autumn a book on computers in law with a  
Professor from Czechoslovakia and also advise on  
computer projects and run computer workshops all year  
long.

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Q. All right. Other than these

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very sophisticated texts you have told us about, what  
kind of specific training have you had? Have you taken  
courses or obtained degrees --

22

23

A. No, I have not. I mean I have

24

25





ANGUS. STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

Gilmour-Bryson,  
cr.ex. (Olah)

1677

K-15

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taken one course in the use of computers, yes, but I  
have taken no Computer Science degrees. The users  
of computers in Humanities none of them possess  
Computer Science degrees, I hire programmers to do that.

MR. OLAH: Thank you.







/BB/ak

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THE COMMISSIONER: Thank you.  
Mr. Tobias?

MR. TOBIAS: I have no questions,  
Mr. Commissioner.

THE COMMISSIONER: Mr. Manning?

MR. MANNING: I have no questions.

THE COMMISSIONER: Oh, well,  
Mr. Lamek?

MR. LAMEK: No, I have no re-  
examination, thank you, Mr. Commissioner.

THE COMMISSIONER: All right,  
thank you. Thank you, Dr. Gilmour-Bryson.

Would this be as good a time to rise  
as any?

MR. LAMEK: It would indeed,  
Mr. Commissioner, because we've got to do a bit of  
re-arranging anyway.

THE COMMISSIONER: All right. Sorry,  
yes?

MR. STRATHY: I would ask,  
Mr. Commissioner, before we break, if Mr. Lamek  
has any handouts that we can digest along with our  
lunch, whether he might make them available to us  
now.

MR. LAMEK: All right, I might be





1  
2 able to do something like that.

3 THE COMMISSIONER: Well, do we  
4 want to come back earlier or what?

5 MR. LAMEK: I think we're into a  
6 long haul when we start the next witness,  
7 Mr. Commissioner. Perhaps we can take the usual  
8 amount of time and come back at 2:15.

9 THE COMMISSIONER: 2:15, all right.  
10 Well then, 2:15.  
11 ---Luncheon recess.

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---Upon resuming at 2:15 p.m.

THE COMMISSIONER: Mr. Lamek?

MR. LAMEK: Mr. Commissioner, may  
I call please Dr. Richard Rowe.

DR. RICHARD DESMOND ROWE, Sworn

DIRECT EXAMINATION BY MR. LAMEK:

Q. Dr. Rowe, you can sit down if  
you prefer to.

A. Thank you.

Q. Dr. Rowe, you are the Director  
of the Division of Cardiology in the Department of  
Pediatrics at the Hospital for Sick Children?

A. I am.

Q. And you are also Professor of  
Pediatrics in the Faculty of Medicine at the University  
of Toronto?

A. Yes.

Q. I promise I will spare you  
as much of this as I can, but I have to touch upon  
the highlights of your career. Your under-graduate  
education was in New Zealand whence you hail?

A. Yes.

Q. And in 1946 you were graduated  
from the University of New Zealand with degrees of  
Bachelor of Medicine and Bachelor of Surgery and





1

2

you subsequently did an internship in New Zealand?

3

A. That's correct.

4

Q. And after a brief stint in the

5

New Zealand Army, you went to the U.K.?

6

A. Yes.

7

Q. Where you served in House

8

Offices, which I understand to be equivalent to a  
residency?

9

A. Yes.

10

Q. At the Leicester Royal Infirmary

11

and subsequently at the Royal Hospital for Sick

12

Children in Edinburgh.

13

A. Yes, correct.

14

Q. And then in 1950 you came to

15

Canada to a residency in Pediatrics at the Vancouver  
General Hospital?

16

A. Yes.

17

Q. And in 1951 until 1954 you were

18

a Cardiology Fellow at the Hospital for Sick Children  
here in Toronto?

19

A. Yes.

20

Q. And thereafter you remained at

21

the Hospital for Sick Children until 1960?

22

A. Yes.

23

Q. At that time you returned to

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New Zealand to take up an appointment as Senior  
Cardiologist at a hospital in Auckland and you  
stayed there until 1963?

A. Correct.

Q. And in 1963 you returned to  
North America and took up an appointment at Johns  
Hopkins Hospital in Johns Hopkins University in  
Baltimore?

A. Yes.

Q. And there you stayed until  
1973, latterly as the Harriet Lane Home Professor  
of Pediatric Cardiology?

A. Correct.

Q. And then, happily for us, you  
returned to the Hospital for Sick Children in  
Toronto to the positions which you now occupy?

A. Yes.

Q. And you are a member of several  
professional societies and organizations and the  
author of articles too numerous to mention?

A. Yes.

Q. I understand too, Dr. Rowe,  
that you are the co-author of three texts: one  
"Heart Disease in Infancy and Childhood", now in  
its third edition?





AA4

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A. Yes.

3

Q. Also "The Child With Congenital

4

Heart Disease after Surgery".

5

A. Yes.

6

Q. And now in its second edition

7

"The Neonate with Congenital Heart Disease".

8

A. Yes.

9

Q. The Curriculum Vitae with which

10

you have provided me is obviously very much lengthier

11

than that brief recital. I wonder, Mr. Commissioner,

12

if we might mark it as the next exhibit.

13

THE COMMISSIONER: Yes, thank you.

14

That will be Exhibit 40.

15

---EXHIBIT NO. 40: Curriculum Vitae of Dr. Richard  
Desmond Rowe.

16

MR. LAMEK: Q. Dr. Rowe, you are

17

the first Cardiologist to give evidence before this

18

Commission and I tell you that we are looking to

19

you to give us some general background and education

20

before we get down to particular matters and cases.

21

Believe me, I don't intend to be offensive if I ask

22

you to sum up your life's work in 10 minutes, but

23

could you tell us please what is cardiology, what

24

do cardiologists do, and in particular, what does a

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pediatric cardiologist do?





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A. Well, a cardiologist is a physician who deals with matters of illness pertaining to the heart, usually predominantly connected with that organ but may be secondary related such as high blood pressure and other similar secondary diseases.

The background training for a cardiologist is usually a primary discipline in internal medicine and then specialized training in addition to that in this study of the cardiovascular system and its diseases.

A pediatric cardiologist is an individual who usually has his primary training in pediatrics and so becomes qualified as a pediatrician, certified as a pediatrician and then takes additional training in diseases of the cardiovascular system pertaining to the age group of pediatrics, which would be from birth through to about 16 to 18 years.

Most of what a pediatric cardiologist does today is related to congenital defects of the heart. He is concerned with that as the bulk of his patient management, but he may also deal with other diseases of the heart, particularly diseases of heart muscle and of diseases even of the arterial system as it affects the heart, coronary artery





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disease.

But the chief occupation relates to congenital heart malformation.

Q. Thank you, Doctor. As we progress with your evidence into the review of particular charts of particular patients who died at the Hospital in the period with which we are concerned, we are going of necessity to be hearing a good deal about heart function, different locations and sites in both heart and the circulatory system, and it may be helpful if at the beginning you give us something of a thesaurus or a guidebook.

The Hospital has prepared for us a couple of diagrams, which are here on easels; one, the thing that looks like a roadmap of Toronto with all those one way streets, I understand to be a schematic drawing of the circulatory system.

A. Yes.

Q. And the other, a diagram setting out the structure of again what I understand to be the normal healthy heart. I think it would be helpful for us, Doctor, and assist our understanding of the evidence that is to come, if you would spend just a few minutes explaining to us just what is shown in these diagrams.







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A. Yes.

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Q. And if you want to walk over to them, there is a microphone here that you can carry with you if you like.

6

7

THE COMMISSIONER: Mr. Lamek, are they reproduced?

8

MR. LAMEK: I'm sorry?

9

THE COMMISSIONER: Do we have copies of them?

10

MR. LAMEK: Yes, we do.

11

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THE COMMISSIONER: Because I can't read the writing but others may well be able to.

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MR. LAMEK: I should say, Mr. Commissioner, that the envelopes that I am handing around at the moment are all prepared by the Hospital and they contain not merely these two diagrams but also a diagram for each of the children upon whose death Dr. Rowe is going to comment, showing the particular malformations or deformations of the heart of that child as compared with the normal heart.

21

22

THE COMMISSIONER: Yes, all right, thank you.

23

MR. LAMEK: Q. Go ahead.

24

25

A. Perhaps I could start with the





1  
2 diagram charted on the left side.

3 THE COMMISSIONER: Can we call that  
4 Exhibit 41?

5 MR. LAMEK: That's the second one  
6 in your bundle I think, Mr. Commissioner.

7 THE COMMISSIONER: Yes.

8  
9  
10 THE WITNESS: Which is the diagram  
11 of the actual heart internal anatomy and then move  
12 over to the other more complex diagram in a minute.

13 The heart is really a double chambered  
14 pump. It consists of two pumps, each of which has  
15 a receiving chamber or atrium, which receives  
16 entrance of veins from different parts of the body;  
17 in the case of the right side, the blood comes from  
18 the systemic veins or the veins from the head and  
19 the neck and the arms and the legs and the abdomen,  
20 and a pump which is below the atrium, which is a  
21 pump delivering blood to a great artery leaving the  
22 heart. In the right side of the heart, the blood  
23 is pumped into the pulmonary artery, which is the  
24 artery conducting blood to the lungs.

25 On the left side of the heart, the  
blood is pumped into the aorta, which is the other





1  
2 great artery and which delivers blood around the  
3 body, as we see on the other diagram.

4 Between these two chambers is a  
5 valve. In the case of the right side it's called  
6 a tricuspid valve, in the case of the left side  
7 it is called a mitral valve, but the purpose of  
8 these valves is the same, when the heart is filling  
9 up into its pumping chamber, that valve opens and  
10 when it starts to pump into the artery leaving on  
either side, that valve shuts.

11 There is a valve which guards each  
12 great artery, so, there are in fact four major  
13 valves in the heart. This is called a pulmonary  
14 valve appropriate to a valve in a pulmonary artery  
15 and the other is called an aortic valve, appropriate  
to a valve in the aorta.

16 Now, the size of the ventricle,  
17 the size of the pump is in the main about 300 grams,  
18 and that would be about the size of a comparable  
19 area of Mr. Lamek's fist.

20 In a baby, the comparable size is  
21 not too dissimilar from a baby's fist because it  
22 weighs only 28 grams at birth.

23 The left sided pumping chamber is  
24 the powerful pumping chamber because it has to  
25





1  
2 deliver blood around the entire body at the level  
3 your arterial blood pressure, but the pump on the  
4 right side is a relatively minor pump, because it  
5 has to slurp blood a very short distance up to the  
6 lungs. So, the left side is a high pressure  
7 chamber, the right side is a low pressure chamber.

8 Now, if we move over to this other  
9 diagram, I don't think I will make it with the mike.

10 MR. LAMEK: The mount will come to  
11 Mohammed, I promise you!

12 THE WITNESS: Virtually the same  
13 diagram is in here as is on the other board, but  
14 the connections are made a little more obvious in  
15 order to identify where the blood comes from and  
16 where it goes.

17 The blue arrows represent the  
18 returning venous blood, which has a low amount of  
19 oxygen in it.

20 So, this comes into the right atrium  
21 and then passes into the right ventricle and does  
22 a U-turn and then goes out to the arteries to the  
23 lung, the pulmonary arteries. That artery is  
24 distributed after it divides into the left side and  
25 one to the left side and as the blood gets into the  
finer radicals of that artery, it gets into an area







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where very small vessels exists and the total exposure to oxygen is an area approximately the size of a tennis court. When the blood is in that degree of minute vessel, it picks up oxygen readily and then comes back as the red arrows here into veins which collect and enter the left atrium.

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The blood then goes down in a manner rather similar to the right side into the left ventricle in a U-turn and is pumped out into the aorta.

From the aorta it is distributed in arterial branches of the aorta up to the head and the neck and the arms as we see here, and when it has gone through its process of giving oxygen to the tissues, it comes back as venous blood again.

Then it turns down in the aorta into a portion of the vessel that descends through the chest into the abdomen and then divides into two branches to give supply to each leg.

The force of the left ventricle as I have said is much more striking and powerful because it has this distance to distribute blood, and the right side, a low pressure just simply slurps blood out to the lung.

The function of these vessels, of these pumps, is determined by a number of factors, the most of important of which is the supply of oxygen to the muscle tissue.

The difference between an adult heart and a baby's heart is considerable at birth, and the reason for this, and why it is important I think,





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because we will be looking at a large number of babies, is that during the existence as a fetus there is very little blood goes through the pulmonary artery branches because the lungs are collapsed. They are not working.

There is very little blood, and perhaps only 10 per cent of the blood being discharged from the heart that gets into the lungs that way, and obviously it has to go somewhere, so it goes out through a channel that is labelled here DA, and it is labelled on the other diagram ductus.

That is a channel which is present and is as large as either the pulmonary artery or the aorta during fetal life because it has to transmit blood that is pumped into the pulmonary artery back into the aortic system.

THE COMMISSIONER: Before you go on, Doctor, there is a small problem. I have no arrows on the picture that has been given to me. Are there supposed to be arrows?

MR. LAMEK: None of us have arrows on the small one, Mr. Commissioner. The arrows were put on in colour later I gather at the Hospital.

THE COMMISSIONER: Well, the problem - I know we can all put the arrows on - but the problem





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is going to be as the Doctor describes here and there, arrows, if we have no arrows it is going to be pretty hard to follow. I don't know how we are going to solve the problem?

MR. LAMEK: Well, Mr. Commissioner, that may be a problem. I propose that we leave - that we mark as an exhibit the large chart with the coloured arrows, and that we leave it there right beside the witness box so that --

THE COMMISSIONER: We can all copy it.

MR. LAMEK: We can either copy it or at least follow when the Doctor points to a particular thing.

THE COMMISSIONER: Yes. All right.  
With that --

THE WITNESS: With that I can proceed?

THE COMMISSIONER: You get interruptions in the classroom?

THE WITNESS: Well, I haven't given this lecture for 40 years.

The situation with ductus arteriosus is that it is a large channel during fetal life, and it is kept open by an active substance in the circulation called prostaglandins.

The work on this particular area of physiology of circulation having been conducted by







BB.4

(2)

1  
2 members of the Cardiovascular Research Focus at the  
3 Hospital for Sick Children, and it is an important  
4 structure insofar as it affects the behaviour of certain  
5 heart malformations after birth. But normally that  
6 structure as soon as the baby is born and expands the  
7 lungs and allows blood to go out into those lungs,  
8 that channel begins to constrict, and it is closed  
9 functionally within 24 to 48 hours after delivery.

10 Nevertheless during that time the  
11 pressures remain moderately high in the pulmonary  
12 artery, whereas they should be, as you know in adult  
13 life, low, and it takes a while for this adjustment  
14 to be completed, varying between about five to ten  
15 days.

16 At that early stage the right side of  
17 the pumping chamber is very thick, just like the left  
18 side of the pumping chamber the muscle is thick  
19 because it has had a lot of work to do in the womb,  
20 and it takes time for that side of the heart to  
21 become the adult thin formation, and that takes  
22 several months.

23 I think those are the main features  
24 of the circulation that are important in the normal.

25 Perhaps a brief comment about the  
electrical system of the heart. Perhaps I could move  
that one over.





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The heart beats not because it has no system, but because there is an electrical system in the heart which permits this to happen.

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Somewhere in this region here, the top of the right atrium and the superior vena cava which is the major vein bringing the blood in from the head and the neck and the arms, there is a specialized nest of tissue which looks a bit like muscle but isn't, and that is the sinus node. It is spelled s-i-n-u-s node. And that is the real transmitter for the heart.

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14

From that area an electrical signal emanates on a regular basis from these special cells and transmits the electrical signal through the top portion of the heart.

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This electrical signal is necessary before the physical contraction of the muscle in the chamber, so the top chamber which is a weak muscular chamber contracts first and then after the electrical signal is gathered at a relay station called the AV node meaning the atrioventricular node, the spot just between the top chamber and the pumping chamber, the AV node then has a specialized bundle of tissue like a nerve which splits into two, one going into each pumping chamber.

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That electrical system is important





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because it is affected by disease of the heart; it  
is affected by drugs such as digoxin and other drugs  
used in the control of rhythm disturbance, and will  
be discussed in some cases as we go along.

I think that is all.

MR. LAMEK: Doctor, thank you.

Mr. Commissioner, perhaps the two  
diagrams could be marked with the next number, perhaps  
A and B, the heart first and the circulatory system  
diagram as B to that exhibit number.

THE COMMISSIONER: 41, I think. 41 A  
and B. 41A then will be the one which has the  
innominate artery at the top and 41B will be the one  
which has right arm, head and neck and so on.

--- EXHIBIT NO. 41-A: Diagram with innominate  
artery at the top.

--- EXHIBIT NO. 41-B: Diagram with right arm,  
head and neck, left arm  
at the top.

MR. LAMEK: Q. Doctor, may we go to  
your division of the Hospital for Sick Children, and  
again to understand the <sup>roles</sup> ~~rules~~ of the players as we  
look at these charts, it would be helpful to know  
something about the staffing and organization of your  
department, And of course I am particularly interested  
in the staffing and organization of the division in





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the period from July, 1980 to March, 1981, but if it has changed since that time in any way that you think we should know about, then would you please tell us.

Would you tell us something first about the ward facilities, the number of beds that are available and so on. And our focus, I should tell you, is on what is now 4A and 4B. That I understand is what the Terms of Reference contemplate.

A. Yes. Do you want me to start with the ward then?

Q. Yes, I think that would be helpful if you could, Doctor. I think that would be helpful.

A. Well, the ward is an area in the Hospital which has two components to it. It is now called Ward 4A but it was 4A and 4B, so there were two wards.

4A had 19 beds as I understand it and 4B, 23, although I have heard a number of other different numbers given from time to time.

4A has 12 infant beds out of its 19, and 4B has 6 infant beds out of its 23.

THE COMMISSIONER: 4A has how many infant beds?

THE WITNESS: 12 infant beds, Mr. Commissioner, and 4B, 6 infant beds.







BB.8

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MR. LAMEK: Q And infant, could you  
define infant for us, Doctor?

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A. Infants would be babies under  
a year or about that age. It would depend a little  
bit on their status and size.

6

7

Q So <sup>of</sup> a total of 42 beds in the  
aggregate, 18 in the aggregate are infant beds?

8

A. Yes.

9

Q Divided as you have told us?

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A. Yes. Now that arrangement is

11

different from what was present on 5A, and the  
reasoning was because in 5A the arrangement for the  
care of infants in terms of the numbers we were having  
to deal with was not regarded as appropriate.

14

Requests therefore came from us for  
a change in the arrangements of the ward, and that  
resulted eventually in the formation of 4A and B.

17

Q How many infant beds had there  
been on 5A?

18

19

A. I think there were 12.

20

THE COMMISSIONER: How many beds all  
told?

21

MR. LAMEK: Q All told, yes?

22

23

A. 36 beds I believe although  
that figure again has varied from one person to another.

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BB.9

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Q. I see.

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A. Including amongst ourselves,

4

but the number is approximately 36 I believe.

5

Q. We have heard, Doctor, that the

6

move from 5A to 4A and 4B was effective as of April 1,  
1980?

7

A. Yes.

8

Q. And at that time therefore there

9

was an increase overall in the number of beds, although

10

the exact dimensions of the increase may be open to

11

some question.

12

A. Yes.

13

Q. And an increase in the number of

14

infant beds?

15

A. Yes.

16

Q. I understand, Doctor, that the

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Cardiology Ward now 4A, formerly 4A/B, is both a

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medical and a surgical ward in the sense that a patient

19

may be there purely for medical treatment or they may

20

be there either prior to going to or coming back from  
surgical treatment?

21

A. Yes.

22

Q. Is that fair?

23

A. Yes.

24

Q. And where is the operating

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BB.10

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surgical facility for your patients?

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A. The surgical facility is on the

4

second floor of the Hospital.

5

Q. And patients from the Cardiology

6

wards go there for surgery to the second floor?

7

A. Yes.

8

Q. And what is the pattern with a

9

surgical patient? What do his movements classically  
tend to be? Assuming that he is admitted to Ward 4A?

10

A. If he comes to 4A he would be

11

prepared, if he is for elective surgery, meaning that

12

it is planned ahead of time, he would be admitted

13

under the surgical - under the surgeon.

14

Q. Yes.

15

A. And his admission arrangements

16

would be handled by the surgical staff and he would

17

be seen in consultation by the cardiologist and by

18

the general paediatric resident usually as well.

19

Then he would be, if there were no

20

further investigations to be done, he would go down

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to the operating room at the appointed time. He would

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have his operation, and from the operating room he

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would be taken directly to the Intensive Care Unit.

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Q. Which is on which floor?

A. On the same floor, the second floor. From the intensive care unit, when it was judged that the situation was stable, usually after one to several days or longer, he would be transferred back to the fourth floor to one or other of those two wards. Then his care would still be under the surgical staff. While he is in the intensive care unit his care is primarily directed by the intensivists. When he gets on to the cardiac ward his care will be the responsibility of the surgeon but there is an extremely close collaboration by physicians, so that in practice a good deal of the management is conducted during the day time when surgeons are largely operating, by the physicians, and he would be discharged by the surgeons.

Q. Doctor, can you tell us something about the medical staffing of the Division of which you are the head? What is the cardiology staffing in medical terms?

A. Well, the medical staff consists, for in-patient work, of primarily full time cardiologists. In other words, they confine their practice to pediatric cardiology ~~to~~ within the walls of the hospital. There were at that time seven







1  
2 Pediatric Cardiologists and they were and are an  
3 unusually senior group. The average time that each  
4 of them has been in consulting pediatric cardiology  
5 practice is about 17 years, and the number of  
6 clinical research papers that has been written by  
7 the group averages over 100. So, it is a more  
8 senior group than average in that situation, I would  
believe.

9 They are assisted in their operations  
10 by a number of trainee pediatric cardiologists who  
11 are called Cardiac Fellows.

12 A Cardiac Fellow is usually a  
13 pediatrician who has completed his training, sometimes  
14 he was certified as a pediatrician, but is usually  
15 always in a position to take such examination and is  
16 beginning his training, or is half way through his  
17 training in pediatric cardiology. So, he is a  
18 reasonably experienced person in pediatrics and  
acts in that sort of capacity.

19 In addition to the Cardiac Fellows  
20 that are present, and we have varying numbers of those  
21 each year, but I think in that year we had about eight,  
I will have to check that number.

22 THE COMMISSIONER: How many, did you  
23 say, you wouldn't give us your guess.  
24  
25





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2 A. My guess is eight; I may  
3 have to check that point, I don't have a list of  
4 Fellows with me for that period.

5 It would be the same group that was  
6 there between July of 1980 and March of 1981 because we  
7 work on the academic year, twelve month period.

8 On the ward, in addition to the  
9 cardiologist and the cardiac Fellow we have general  
10 pediatric residents in training. At the time of this  
11 period under discussion there were three general  
12 pediatric residents at varying stages of their  
13 training in pediatrics. On the basis of what went  
14 on one day or one month, the cardiologist would be  
15 assigned to that ward for a period of one month,  
16 and the Cardiac Fellow and the residents would be  
17 there for about the same period of time, sometimes  
18 it was five weeks or six weeks for them.

19 The team, therefore, the medical team  
20 on the ward consisted of one staff cardiologist,  
21 one Cardiac Fellow and three general pediatric  
22 residents during the day. The day for us is defined  
23 as around 8:00 in the morning to 5:30 for the  
24 purposes of the duty change. I wish it were that  
25 short most of the time.

The group that then takes over on the





1  
2 night call, for night duty, is another group which  
3 consists of one staff cardiologist, who may or may  
4 not be the ward chief, one Cardiac Fellow and  
5 usually one resident, one general pediatric resident.  
6 The handover of responsibility is conducted around  
7 4:00 in the afternoon, between 4 and 4:30, and  
8 the group meet with the previous shift, as it were,  
9 and all the problems and the cases that need special  
10 care are reviewed. That team takes over for the  
11 night. The staff cardiologist and the Cardiac  
12 Fellow, in addition to looking after that ward, how-  
13 ever, have to look after any emergencies that come in  
14 that have cardiac problems for the whole hospital,  
15 and they carry that function out until 8:30 the next  
16 morning and then they hand over again to the regular  
17 team.

16 At weekends the situation is rather  
17 similar. The staffing at weekends being the staff  
18 cardiologist, a Cardiac Fellow and a resident.

19 Q. Doctor, with respect to the  
20 night team that you have described comprising one  
21 staff cardiologist, one Fellow and a pediatric  
22 resident, is each of those people physically on  
23 the premises of the hospital throughout the night?

24 A. No. The ward chief, or the  
25







Rowe  
In-chf. (Lamek)

1  
2 staff cardiologist usually leaves at some period  
3 that he selects, depending upon the state of the ward,  
4 or the state of the cardiac situation throughout the  
5 hospital. So he may leave at 6, 6:30 or 7, or he  
6 could leave at 11 or 12 or 1, depending upon what  
7 he has to do. The same thing is true of the Cardiac  
8 Fellow, but he does not sleep in the hospital either.  
9 So, the only person who sleeps in the hospital is the  
10 General Pediatric resident, but the others have  
11 beepers and they are available at a moment's notice  
12 and have constant communication availability.

12 Q. You have referred a couple of  
13 times to somebody called the Ward Chief. Can you tell  
14 us, please, what a Ward Chief is, in your Division.

15 A. In that particular time  
16 period, we are talking about 1980 to 1981, we had  
17 only one cardiologist on the ward and he was called  
18 the Ward Chief of the month. We now have two cardio-  
19 logists on the ward and they are called Team  
20 Cardiologists, not Ward Chiefs, because there can't  
21 be two chiefs.

21 Q. It depends how many indians  
22 there are. Let me understand you, Doctor. You told  
23 us that you had staff cardiologists, I think you said,  
24 numbering eight or nine in number?  
25







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A. Staff cardiologists was

3

seven.

4

Q. I'm sorry, seven at that time.

5

One of them was in charge of the ward for a month at  
a time, do I understand that?

6

A. That is correct.

7

Q. What were the others doing

8

during their time not to be ward chiefs?

9

A. This system was introduced in

10

1974 of having a rotation of staff cardiologists

11

through the wards, and through the other areas of

12

the hospital in which they are involved. Because of

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the increasing complexity of the investigative

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procedures that were necessary to look at both

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babies and older children with congenital

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malformations of the heart. Part of that time the

17

seven cardiologists had their own patients on the

18

floor and rounded themselves when responsible only

19

for those patients they had of their own on the

20

floor. But as the investigative tool was expanded and

21

new procedures became available, it was quite clear

22

that this was a pretty inefficient way of doing it,

23

to have somebody being on the ward, then dashing

24

off to see a patient in the out-patient department

25

and going up to the catheterization laboratory to do





1  
2 an exercise test somewhere else. So the Division of  
3 Cardiology was sectionalized at that time and I assigned  
4 the cardiologists the responsibility for administrative  
5 actions in certain areas.

6 There was appointed a Director of  
7 Clinical Service. That individual was a cardiologist  
8 and he was responsible for arranging the rotation of  
9 people through the clinical service and for all  
10 administrative aspects of it. As well as spending a  
11 good deal of his time throughout the year on that  
ward.

12 Then we made another person the head  
13 of the Cardiac Catheterization Laboratories, where  
14 we had at that time a very large load, which was  
15 really extremely heavy. That individual had to set  
16 about administering that area and arranging the  
17 appropriate timetables and portions of peoples'  
times on a rotating basis there.

18 Another section that was formed was  
19 the Heart Station. The Heart Station is an area where  
20 electrocardiograms and exercise tests and  
21 echocardiograms, or cardiac ultrasound are performed,  
22 and that required two cardiologists because that is  
very heavy role.

23 We also had to look after other  
24  
25





1  
2 sections of the hospital as far as the cardiology  
3 is concerned, because the cardiac ward represents only  
4 about half the total of the in-patient work that we  
5 have to do. The other very heavy area is the  
6 7-G or neonatal unit which has a continual input  
7 of babies who, amongst all the other problems that  
8 may exist there, have congenital heart disease as  
9 well. This way, the load was divided up on a  
10 rotational basis so that people at least were not  
11 totally exhausted all the time and were able to  
12 accomplish not only, in our view, a more efficient  
13 clinical service, but also to have some time to do  
14 other parts of their professional activities.

14 Q. It sounds rather like a  
15 complex organization, but I have no doubt that it  
16 works. Doctor, let me be clear that I understand it.  
17 If I, Dr. Lamek, am a cardiologist on your staff and  
18 it is my month to be Ward Chief, and a patient  
19 is referred to you, Dr. Rowe, it is not your month  
20 to be ward chief, can you tell me how between the  
21 two of us the management of that child is going to  
22 arranged?

22 A. Yes. The patient that may  
23 be referred to me may be a patient that I might see  
24 in an out-patient setting before I admitted him to you,  
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but I would admit that individual, as we have all  
argued to do over the years, under your care, and  
you would be the responsible physician for that  
patient during the time that you are the ward  
chief. As long as that patient doesn't become  
surgical, because if it becomes surgical in the  
course of your wisdom you decide it is a surgical  
problem, then you will hand it over to one of the  
surgical people, but in the medical issue you would  
remain the responsible physician.







B/ak

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3 Now, you would therefore maintain a  
4 contact with those parents, with the parents of  
5 that child, and you would maintain contact with the  
6 physician who referred the patient to me. We pay  
7 particular attention to this communication because  
8 of the obvious considerations of communication in  
9 that situation, and although that is an unusual way  
10 of handling practice, as it were, and although it  
11 is strange for many parents to find that sort of  
12 practice going on, we have not had serious trouble  
13 with people understanding the reasons behind the  
14 need and to feeling quite comfortable about the  
15 arrangement.

16  
17 So, at the time of the discharge,  
18 and at various points of perhaps crisis throughout  
19 that admission, you would be informing me, and  
20 perhaps even having conversations with me about  
21 management course, so that the input that I would  
22 have would be something that you would look after  
23 and make sure was accommodated because in the long  
24 term I would be following that patient on a long  
25 term follow-up arrangement.

26  
27 So, at the time of discharge you  
28 would say to me, Dr. Rowe, I'm about to discharge  
29 this child, this is the situation we're at now, do





1  
2 you have any further comments and when would you  
3 like to see the child back again.

4 Q. Can you tell us something about  
5 the nursing staffing of the Cardiology Wards? Again,  
6 I'm thinking particularly of the period with which we  
7 are concerned, but again I say to you, Doctor, if  
8 there is something that has happened since that you  
9 think we should be aware of, then by all means tell  
10 us that too.

11 A. Now, I should point out that  
12 the nursing staffing is not under our control, not  
13 even the numbers are under our control. I can only  
14 tell you what I understand the nursing arrangement  
15 to be and I think that if you want very fine detail  
16 about that, it would be necessary to speak to the  
17 nursing group.

18 But our understanding of the arrange-  
19 ment was that there was a head nurse on each side  
20 and a clinical instructor.

21 Q. When you say on each side, you  
22 mean one in 4A and one in 4B?

23 A. Yes.

24 Q. Yes.

25 A. A clinical instructor, there  
was a nursing team on each side at any one time and





1  
2 there might be other people during the day, such as  
3 nursing students and others.

4 The same theoretic number were present  
5 at night but there might be fewer. I think that at  
6 various times that was a particularly difficult time  
7 for nursing because of the shortage of nurses and  
8 I think they had great difficulty at times of illness  
9 and vacation and other things and in filling the  
10 numbers adequately, although, they performed a  
11 superb job in looking after this difficult problem.

12 Q. When you say at that time,  
13 Doctor, you are referring to the summer of 1980 to  
14 the early spring of 1981?

15 A. Yes.

16 Q. I have to ask you, is it  
17 your recollection or your impression, or do you have  
18 some firm information that you can give to us as to  
19 the shortage of nurses that you have just suggested?

20 A. I cannot answer that question  
21 directly. All I know is that we had a very firm  
22 impression amongst the cardiologists that there was  
23 difficulty with staffing periodically and often at  
24 night.

25 Q. Is it your recollection that  
that impression of shortage was focused in the







1  
2  
3 period with which we are concerned or did it also  
4 occur at periods in your recollection at the  
5 Hospital?

6 A. Oh, I think it has occurred  
7 at other periods as well, but I believe that was a  
8 particularly bad time.

9 Q. There is nothing you can  
10 provide to us by way of data or statistical informa-  
11 tion on that?

12 A. No. I wouldn't be able to  
13 say most of the time exactly how many nurses are on  
14 the floor but I am informed that there is a team on  
15 each side and we definitely had an impression of  
16 difficulties from time to time in staffing.

17 Q. Well, perhaps we can come back  
18 to that one, Doctor, I intend to.

19 I take it that most of your patients,  
20 the patients in your division, are referrals from  
21 other hospitals, outside pediatricians, outside  
22 general practitioners, things of that sort?

23 A. Yes, they are. 60 per cent  
24 of the patients we see come from outside of  
25 Metropolitan Toronto.

Q. I'm sorry, what was that?

A. 60 per cent of the patients we







1  
2 see come from outside Metropolitan Toronto.

3 Q. And I think you have told me  
4 something of the ~~patent~~ <sup>pattern</sup> that might be followed if,  
5 I as an outside pediatrician, for example, believing  
6 that a patient of mine has a heart problem, refer  
7 him to you, you may see him initially in consultation  
8 or in the clinic, but unless you happen to be Ward  
9 Chief of the month when he is admitted to the ward,  
10 you may or may not have close contact with him. Do  
11 I put that fairly?

12 A. That's fair. ~~You~~ <sup>I</sup> might have  
13 contact with him because I might have contact with  
14 the patient because I might be on duty one evening.

15 Q. Yes.

16 A. While he's on the ward, or I  
17 might be in the Cardiac Catheterization Laboratory  
18 when he is being studied.

19 Q. Now, we heard something this  
20 morning about cardiac catheterization, and it is  
21 something that you yourself have referred to, Doctor.  
22 Can you tell us what is cardiac catheterization?

23 A. Cardiac catheterization is  
24 a technique, a diagnostic technique for the most  
25 part, although, it may be therapeutic under certain  
circumstances, in which a fine plastic tube specially





constructed is passed through a vein usually in the leg and is passed up towards the heart under the control of an image amplifier, which is a radiological piece of equipment.

Q. Image amplifier?

A. Yes. It is a technique of being able to visualize by extra the area of the heart using relatively low doses of radiation. The catheter would pass up from below, for example, through what is labelled there IVC.

Q. Right.

A. Which is the inferior vena cava and would enter the right atrium and then could be passed through the tricuspid valve to the right ventricle and floated out to the pulmonary artery.

So, you have a catheter which will pass, a hollow catheter which passes out to the artery and through that catheter, which has a hole at its tip, pressures can be measured and samples of blood examined for oxygen and other substances.

In a similar way, a catheter can be placed in the artery of the groin and advanced retrogradely.

Q. Up through the aorta?

A. Up through the aorta, around the





1  
2 arch of the aorta and down across the aortic valve  
3 into the left ventricle and sometimes into the  
4 left atrium.

5 So that with this technique,  
6 pressures and samples and injection of materials  
7 can be made at any point in the heart so detailed  
8 information about the function of the heart, the  
9 pump as it were, and pictures which are then obtained  
10 by injecting material and taking cine film will show  
the internal architecture of the heart.

11 More and more today, this approach  
12 is also being used for therapy and it is possible in  
13 some of the conditions about which you will be  
14 hearing, I'm sure, to note that in some patients  
15 with certain malformations it becomes important to  
16 make a hole in the heart, not to the outside of  
17 course but within the walls between the two pumps,  
18 and that technique has been used as well as other  
19 techniques which have been used to close holes. So,  
20 you can make them and you can close them with this  
technique, as well as add diagnostic information.

21 Q. Okay. Focusing again on the  
22 period from July '80 to March '81, Doctor, was the  
23 cardiac catheterization procedure a frequently used  
24 diagnositic technique on the Cardiology Wards?  
25







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2

A. Yes.

3

Q. I have one observation about

4

it, that it sounds remarkably unpleasant to have to

5

undergo. Is this a difficult or stressful experience

6

for infants?

7

A. I think it is stressful for

8

everybody.

9

Q. Well, I'm sure it would be for

10

me.

11

A. Yes, I think it's not exactly

12

a pleasant experience for anybody. Babies, generally

13

speaking, have the procedure done without a general

14

anesthetic; older children have a heavy sedation

15

but younger babies don't require more than the

16

use of local anesthesia. Because they are sort of

17

wrapped up and they're in a warm environment and

18

they are looked after by a specific individual

19

during the test, he has no other job except to make

20

sure that the baby is comfortable, and in most cases

21

the procedure is accomplished without apparent

22

great discomfort to the baby.

23

Q. Well, the catheterization lab

24

is on the fourth floor, is it not, Doctor?

25

A. Yes.

26

Q. The other thing that we have

27

28







1  
2 heard about is echocardiogram, and you yourself have  
3 referred to that. Can you tell us what that is?

4 A. The echocardiogram is a form of  
5 ultra-sound in which extremely high frequency sound  
6 waves are generated from a transducer or crystal  
7 and passed and directed through the chest wall from  
8 the outside in the direction of the heart. The  
9 sound waves on striking different interfaces between  
10 blood and tissue will reflect back to the transducer.  
11 So that there is a signal of output and there is a  
12 signal of return.

13 With the modern day instrumentation,  
14 which takes a two dimensional look at the cardiac  
15 structures, it is possible to see on screens through  
16 computerization of the data, the actual visible  
17 motion of the heart structures very, very much as  
18 you see it on that diagram; not quite as simple as  
19 that.

20 Q. And without the labels I take it?

21 A. Without the labels, yes. It  
22 is as great an attraction as it is a non-invasive  
23 method as opposed to cardiac catheterization, which  
24 is an invasive tool and to some substantial degree,  
25 it is now replacing the need for cardiac catheteriza-  
tion in certain situations, not unfortunately in all,





1  
2 but in an increasing number.

3 Q. Were the two techniques  
4 available and in use at the hospital during the  
5 period that concerns us, Doctor?

6 A. They were, but I would say that  
7 the two dimensional technique that we were using  
8 then was relatively primitive by even current  
9 standards.

10 Q. Now, let's assume a situation,  
11 Doctor, in which an initial diagnosis made of a  
12 patient and the diagnostic techniques of the  
13 kind you have just described are used to either  
14 corroborate or confirm or change that diagnosis and  
15 it is thought by the cardiologist in charge of  
16 the case that this patient may be candidate for  
17 surgery. I'm not talking now about an emergency  
18 situation, elective surgery. Can you tell me, by  
19 what procedure is that decision made, who is involved  
20 in the making of that decision?

21 A. The person who is the responsible  
22 cardiologist will raise that patient's name and  
23 material, clinical evidence at a special conference  
24 which is held once a week on the Cardiac Ward  
25 between the Cardiologists and the surgeons.

So that a proposal is made to





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consider this patient's problem as a surgically  
treatable condition and the material is examined  
by the entire group, which might be as many as  
30 people. Most of those people don't know this  
patient at all, but they will see the data upon  
which the proposal is being based and if there  
are major discrepancies in the opinion of people  
or if the surgeons have a particular concern about  
any aspect of it, then it will be the subject of  
further debate.

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By and large, most patients who reach that point have been pretty thoroughly worked out and the decisions for the most part are fairly routine. But there are numbers of patients in which -- in whom the decision is very much more difficult to make from a surgical standpoint, and that does require quite a lot of discussion.

Q. There is one term, Doctor, that we may come across from time to time in considering these charts. It has a ring to it. It is "heroic surgery." Can you tell me what is meant by heroic surgery?

A. Well, I suppose many people might have different definitions. I think, perhaps, in terms that it has been used in our division and the surgeons with us would be a surgical operation for which either the state of the patient is so -- has so deteriorated that the prospect of being able to accomplish anything is almost nil, or there is a new operation for a condition which otherwise the patient would receive no treatment and would automatically and inevitably die. And there are not too many of those situations, but there are certainly some.

Q. Dr. Rowe, I take it that many very seriously ill cardiac patients are admitted to







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2

2

your wards?

3

A. Yes.

4

Q. And that I would take it, too,

5

that some of them have such serious heart defects

6

and problems or heart disease that they simply cannot  
be made better. Is that fair?

7

A. It is fair.

8

Q. I take it some of them decline

9

and deteriorate and eventually die?

10

A. That is true.

11

Q. We are going to be hearing

12

certain terms quite often, Doctor. I think we ought

13

to have your definition or understanding of them, if

14

you would, please. We see the term "arrest".

15

Can you tell us -- arrest, in the  
language of lawyers usually means something rather

16

different, but if anything, a little less unpleasant.

17

Define arrest for me, please, Doctor.

18

A. Arrest means stopping.

19

Q. Yes.

20

A. And the term is rather

21

loosely used, as you have already suggested in

22

medicine, because one should qualify it with what

23

type of arrest, whether it is respiratory arrest

24

or whether it is cardiac arrest. But since the two

25





1  
2 are very closely connected, I think it is not  
3 unreasonable to simply call it arrest in a practical,  
4 working man's language, as it were.

5 Q. All right. Is that equivalent  
6 to what, before people started looking at brain  
7 activity, used to be called death?

8 A. Yes.

9 Q. We are also going to come  
10 across the use of codes to summon assistance in  
11 cases of arrest or threatened arrest.

12 Can you tell us, please, whether  
13 the system of codes for emergency treatment was in  
14 effect in the hospital in the period that we are  
15 talking about?

16 A. Well, I am most familiar  
17 with Code 25 which is a call for cardiac arrest  
18 or respiratory arrest, which is generated by a  
19 nurse or a physician, whoever happens to be there.

20 Q. Yes.

21 A. And that leads to the  
22 appearance of a flying squad within the hospital.  
23 I am less familiar with Code 23 because I never had  
24 occasion to use it myself, but I think, my under-  
25 standing of a Code 23 is that it is a stage less  
than cardiac arrest.





1

2

Q. You have never been summoned by  
a Code 23, Dr. Rowe?

4

A. I don't think I have.

5

6

Q. Code 23, do I understand it  
correctly, it is a call for a particular physician?

7

A. Yes, it is for a resident  
physician who is a part of the ward structure.

8

9

Q. And a Code 25, in effect, says  
get here fast; someone is in serious trouble.

10

11

A. Yes, and that is a much more  
highly organized team arrangement.

12

13

Q. Yes. That team is not  
comprised solely of people from the cardiology  
division, is it?

14

15

16

A. No, there would not be a  
cardiologist necessarily involved in that unless  
he is called subsequently.

17

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The people who are on that team are  
the senior pediatric resident, an anesthetist, I  
believe a general surgeon. I think there is now a  
respiratory technician as well, and the nurses join  
this team in an automatic way who are involved with  
the patient and sit about their role in the  
team in a fairly standard fashion, supplying the  
equipment and the drugs that are ordered by the





1  
2 physicians who are involved. That is not really of  
3 necessity a function of a cardiologist to be on a  
4 25 team.

5 What you need are people who are  
6 trained in cardiopulmonary resuscitation, who are  
7 used to dealing with that sort of problem. It may  
8 be a disadvantage to have a staff cardiologist on  
that sort of a team.

9 Q. Doctor, I am going to suggest  
10 a short break in just a moment, but could I just  
11 end with this: a couple of more questions on this  
12 business of the arrest team, the resuscitation  
13 team, call it what you will. I gather upon the  
14 sounding of a Code 25, that team is summoned to a  
15 particular location, not to a particular patient,  
is that right? The call to a ward?

16 A. Yes, I believe that is true.

17 Q. And they don't bring their  
18 equipment and things with them? There is on the  
19 ward, as I understand it, something colloquially  
20 called a crash cart or resuscitation kit or cart.

21 A. Yes.

22 Q. And the team and the cart are  
23 brought together to the patient's bedside?

24 A. Yes.  
25







1 MR. LAMEK: Okay. Would it be an  
2 appropriate time, Mr. Commissioner, to take a short  
3 break?

4 THE COMMISSIONER: Yes. Fifteen  
5 minutes.

6 ---Short recess.

7 THE COMMISSIONER: Mr. Lamek?

8 MR. LAMEK: Thank you, Mr. Commissioner.

9 Q. Dr. Rowe, just immediately be-  
10 fore we broke for recess you told me that there was,  
11 and I think you said an outside study which showed  
12 that there was, I think eleven per cent success  
13 ratio, you said, on Code 25 resuscitation efforts  
14 in the cardiology ward.

15 Can you tell me, please, who did that  
16 study?.

17 A. I believe that was the Centre  
18 for Disease Control.

19 Q. All right. And that is perhaps  
20 something we will hear about at a later stage.

21 A. Yes.

22 Q. Doctor, we were talking about  
23 the sad end of some of the patients who come to your  
24 cardiology wards at the hospital. Is it fair to say  
25 that speaking generally those patients of yours who  
die do not die on the ward? Is that fair, as a general  
statement?





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A. On the cardiac ward as opposed to any other ward?

Q. Yes. On the cardiac ward, 4A and 4B in the period we are talking about.

A. Yes. I would think the bulk of the patients die in other areas.

Q. I take it that many of the mortalities would occur, for example, in the operating room or post-operatively in the intensive care unit?

A. Yes.

Q. Or if a child is seen to be declining and becoming in serious risk of death, he may be transferred from the ward to the intensive care unit, and if he continues to decline will die there rather than on the ward? Is that fair?

A. Yes. There would be some exceptions to that. On occasion we would send a patient who had an inoperable, inevitably fatal condition back to the hospital from which he had been sent.

Q. From which he came, yes. But of the patients that you lose in the hospital from the cardiology wards, I take it most of them would be patients who go to surgery and never make it back to the ward or go to the ICU from the ward





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and never make it back to the ward either?

A. Yes. A considerably higher  
proportion than on the ward itself.

Q. Than on the ward itself.  
Now, I think you were at the hearing this morning,  
Doctor?

A. Yes.

Q. And you heard evidence given  
by Dr. Gilmour-Bryson?

A. Yes.

Q. Which seemed, if I may say so,  
to be corroborative of what you just told me;  
normally relatively few children die on the cardiac  
ward itself.

A. Yes.

Q. When one of your patients does  
die, is there any system or practice of reviewing or  
discussing that death?

A. Well, we go through a process  
of review on all deaths which is on a day by day  
basis, and it concerns death of any cardiac patient,  
no matter where it is in the hospital.

Q. Yes.

A. So that we would discuss  
death in that review, had it occurred in the cardiac







1  
2 ward or in the operating room or in the intensive  
3 care unit or the neonatal intensive care unit, and  
4 occasionally on some other ward.

5 Q. Those reviews are conducted  
6 daily?

7 A. On a day to day basis, when-  
8 ever death occurs, that would usually be initiated  
9 by the cardiologist and the cardiac fellow involved  
10 in the situation of the death at the morning  
conference on the day following the death.

11 Q. There is a daily conference  
12 of cardiologists?

13 A. We have a daily work  
14 conference at 8:30 every morning, Monday to Friday.

15 Q. And if in the preceding 24  
16 hours there has been a cardiac death, that death is  
discussed at that meeting?

17 A. At that meeting, immediately. Not  
18 all of the information that is available on that  
19 patient ultimately will be available then, but  
20 there is an initial discussion about that infant  
21 and that has importance today more than it had in  
22 the past because a great deal of the anatomic and  
23 other information about patients today is known prior  
24 to their death.  
25







1  
2 Twenty years ago, 15 or 10 years  
3 ago there might be some surprises in the underlying  
4 findings, but in the initial evaluation, that  
5 information, the confirmation of the diagnosis may  
6 not be possible because the autopsy information  
7 may not be on hand.

8 But the following day a preliminary  
9 report of the gross anatomy of the heart will be  
10 provided to us by Dr. Robert Freedom.

11 Q. If there has been autopsy,  
12 I take it.

13 A. If there has been an autopsy  
14 and that is a variable percentage, but it is fairly  
15 high in cardiology patients, and that autopsy would  
16 have been conducted by the Department of Pathology  
17 and Dr. Freedom is a member with <sup>a cross-</sup> ~~of course,~~  
18 appointment in pathology as well as in pediatric  
19 cardiology, so he consults with the pathologist  
20 who performs the autopsy and he gives us a verbal  
21 report.

22 Now, the detailed report of  
23 that information takes some time to develop because  
24 of the nature of the examination requiring histologic  
25 examination, microscopic examination and so on.  
But we have a fairly good idea of the circumstances





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found at the autopsy the next day.

Q. Doctor, may I interrupt you?

A. Yes.

Q. Just so that I am sure, then, if a patient were to die on, let us say, Ward 4A today --

A. Yes.

Q. You, at your cardiology meeting at 8:30 in the morning, tomorrow morning (assuming you are there and not getting ready to come here), you would expect there to be a discussion of that death?

A. Yes.

Q. At which the cardiologist who would be responsible for the case, the resident, would tell you of the circumstances as he knew them, the condition of the child, if known.

A. Yes.

Q. And then on Thursday morning, I take it, you would expect there to be available, probably through Dr. Freedom, the preliminary information from the autopsy, had there been one, information as to the gross anatomy of the heart, any deformation or defects.

A. Yes.





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Rowe  
In-chf. (Lamek)

1733

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Q. Either confirming what had

3

been diagnosed or adding to what had been known.

4

A. Yes.

5

Q. Do I understand that far?

6

A. That is correct.

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Q. Are there any notes, or minutes or records kept of those daily discussions, Doctor?

A. No. Well, when I say no I mean that there is no formal minutes kept of the meetings. They are work meetings in which we deal with, death is only one of the components of the meeting and the rest of the meeting concerns the distribution of work for that day and the results of investigations from the previous day and matters of that sort. It is a very well attended meeting, all the Division comes to that meeting, there are no absentees unless they are sick or on vacation.

Q. I think I understand your meaning. What is the purpose in discussing death in those daily meetings?

A. Well, it is a form of quality control, if you like. It gives an opportunity if there is any unusual feature, or something that was omitted in the management, or something that might have been done differently in the management, to be expressed, and for people to take note of that.

Q. Other than in the daily cardiology work meetings where cardiac deaths may be discussed, are such deaths discussed at any other kind of conference, meetings, review sessions, anything of that sort?







FF.2

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A. There is another meeting that we have with the surgical staff each week which concerns surgical patients that we are proposing for surgery and a description of the operations that the surgeons have done during the previous week, and the outcome of the surgical deaths is discussed then.

There is a review conducted independently of us in two other areas of the Hospital. The Pathology Department has a monthly review of its autopsies, and since about a quarter of their work it seems to me concerns our Division, that is a fairly substantial number of cases that they see, and therefore will be reviewing on a monthly basis. Maybe even weekly, I think it is frequent and obviously very detailed. That is not attended by our staff.

Q. That is not attended by your staff?

A. No, so it is an independent sort of review of the situation.

Q. Does Dr. Freedom not attend?

A. I am not sure if Dr. Freedom attends or not.

There is another meeting at which the cardiovascular surgeons review, in their own Division, the deaths that have occurred in the operating room

Not so! This is the usual breakdown.  
One of the remarkable features of our  
period was that ward deaths in 4A/B  
attributed to OR and OR/ICA deaths!



FF.3

1  
2 or the Intensive Care Unit after surgery.

3 Now in the period that we are talking  
4 about here, that is 70 per cent of the deaths are  
5 surgical patients, one way or another. So they do  
6 an independent review of their own apart from their  
7 review they have with us and that is more of a detailed  
8 review in terms of surgical techniques I believe,  
9 although we do not attend it, mainly because it is a  
10 stitching exercise and that sort of detail that we  
wouldn't have interest in particularly.

11 That material is then summarized and  
12 sent to a departmental meeting of surgery, a review  
13 of mortality throughout the whole Surgical Department  
14 of the Hospital I understand, so that has another  
15 addition to the width of their review. That is seen  
16 by people who have no relation at all to the cardiology  
or cardiovascular surgery.

17 The only other meetings that we have  
18 in this regard are that usually during the year we  
19 have cardiac pathology conferences which are about  
20 once every two weeks usually. They were not once  
21 every two weeks during the period we are discussing,  
22 but that has been in operation since 1974 and there is  
23 a very detailed examination of individually selected  
24 patients. It is a conference which has the purpose  
25 of going into one or two cases in depth, and also has





FF.4

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the importance of being an instructional conference  
for trainees.

3

4

Q. On what basis are those cases  
selected, Doctor?

5

6

A. They are selected by the  
cardiac pathologist in the Department of Pathology  
in conjunction with Dr. Freedom it is a jointly-run  
conference.

8

9

10

Q. You said over the course of a  
year cardiac pathology meetings are held once every  
two weeks?

11

12

A. Yes.

13

Q. And have been instituted I think  
you said in 1974?

14

15

A. Yes.

16

Q. Is that one of the things that  
you instituted after you became Head of the Division?

17

18

A. Well, I am not sure it wasn't  
in course before. I think this has been a meeting  
which had been developed previously but it was put  
into its present format in the time I have been there.

19

20

21

Q. You said it did not meet every  
other week during the period concerning us, that is  
to say July 1980 until March 1981?

22

23

A. That is correct.

24

25







FF.5

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A. That is correct.

3

Q. How often did it meet?

4

A. During that period there were only the two meetings during that period. The reason for that is that the cardiac pathologist of the Department had left, this was an interim period and the Department of Pathology was seeking a replacement and so there was not one, and for that reason we didn't hold regular conferences because they have more teaching conferences requiring the presence of that sort of expertise so it was held in abeyance.

10

11

12

Q. When were the two meetings that were held, held?

13

14

A. I believe they were in September and October but I don't have - oh yes, I have the dates here, the 29th of September, 6th of October.

15

16

17

Q. When prior to the 29th of September had there been one of these meetings?

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19

A. I think they were in the spring of the same year.

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Q. Had it been the practice in the past to hold those meetings in abeyance over the course of the summer?

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A. Usually, but not always.

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Q. Now, did any of these discussions







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and reviews and so on that you have told us about routinely go behind the clinical group that were directly involved? For example, to the Hospital Administration and to that newly formed Risk Management Committee? Was there any regular reporting of the discussions of these meetings outside the particular group involved?

A. No. The Risk Management Committee was not formed at that time.

Q. When was that formed?

A. It was officially formed I believe in the fall of 1980 but it wouldn't have its meeting until the beginning of 1981.

Q. Just one other aspect of the general operation of your Division, Doctor, that I would like to hear from you about. That is the question of reporting deaths to the coroner. Can you tell me how and by whom the decision is made whether a particular death is one that should ~~not~~ be reported to the coroner?

A. First I could say by whom. The report to the coroner was usually made by the staff cardiologist and he made that decision perhaps on his own, perhaps in conjunction with others, frequently in conjunction with others. That would be, if there





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were very unusual circumstances surrounding the death, it was commonly the case that patients who died in the operating room would be reported to the coroner. That would be of course through the surgical people, the surgeons. The deaths in the Intensive Care Unit might or might not be reported to the coroner, and that would be the responsibility of the intensivist, although again there would probably be others enter into it.

On the ward it would be solely the responsibility of the cardiologist.

THE COMMISSIONER: I am sorry, the responsibility of the --

THE WITNESS: Of the cardiologist, and the cardiologist would have to be responsible for that in the same way that any physician is responsible for making that decision to the coroner.

MR. LAMEK: Q. You say the cardiologist, you mean in the case of a nighttime death the cardiologist on call that night?

A. Yes.

Q. Or in the case of a daytime death, the ward chief?

A. Yes.

Q. Do you have any statistics,





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Dr. Rowe, as to the number of deaths that were reported to the coroner in the period which is of interest here from July 1980 to March 1981?

A. I believe I ---

Q. I mean from the cardiology wards?

A. I have only the precise figures for July to December because that was the period which we have particularly emphasized in our reviews.

Q. Yes.

A. In the period of July to December 1980, I believe there were 30 deaths. You have added another death which was June the 30th.

Q. Oh yes.

A. But I haven't added that to this list.

Q. From July 1?

A. That would make the figures look better as they say, but the 30 cases that are involved here, there were nine reported to the coroner, nine of the 30 total cardiac deaths that we considered in that area.

Q. Do you know how many of the 30 total cardiac deaths as you have described them were deaths which actually occurred on Ward 4A or Ward 4B in the six-month period we are talking about?







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A. I think that would be two, I am  
sorry, three.

Q. Three reported deaths?

A. Three reported deaths.

Q. Three reported deaths in respect  
of deaths which occurred on 4A or 4B between July 1  
and December 31?

A. Yes. One of those three was a  
patient who was transferred to the Intensive Care Unit  
from the Catheterization Laboratory but we count that  
as a fourth floor death.

Q. Didn't actually die on the ward?

A. No.

Q. And therefore two children who  
died on the ward in that six-month period had their  
deaths reported to the coroner?

A. Yes.

Q. I am sure we will come to them  
as we get into the evidence, Doctor. Perhaps you could  
give us the names now so I will remember them?

A. Yes. They are Dawson and  
Velasquez.

Q. Now, Dr. Rowe, can we move now  
to the late summer, early fall of 1980, in that period,  
and I am thinking of August to September of 1980. Did  
it come to your attention that there had been, I use







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this word advisedly, an unusually high number of deaths on the Cardiology Wards in July and August. By Cardiology Wards I shall mean throughout Wards 4A and 4B. Did that come to your attention at the end of the summer of 1980?

A. Yes.

Q. You told me of the daily meetings of your cardiologists, 8:30 every morning. Had you observed by the time August rolled around that in July there had been five days when a death on the ward had been discussed?

A. Yes.

Q. And another five in August when a death on the ward had been discussed, were you aware of that?

A. I was aware of that. I was aware of the first lot at the beginning of August of course when we totalled up the figures.

Q. Yes.

A. And the second lot at the end of August.

Q. Could we just be sure of the people we are talking about so that we have the chronology in sequence and I hope we are in agreement, Doctor. The deaths in July as I understand it had





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been those of Alan Perreault on July the 8th; Andrew  
Bilodeau on July the 22nd; David Taylor on July the  
27th; Amber Dawson on July the 28th; and Lillian Hoos,  
H-o-o-s, on July the 31st, is that in accordance with  
your understanding?





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Q. And as you have said, there had been a death also on June the 30th on the ward, that of Laura Woodcock?

A. Yes.

Q. Now, I pause there. You say that as at the beginning of August, you were aware of those deaths? I don't for a moment, Doctor, suggest that you would or should have considered it at the time, but is it fair to say, looking back now, that the on-ward deaths in the months of July were at a level that you had, according to the information we received this morning, at a level that you had experienced over the whole of the last nine months. In the last nine months there had been five on-ward deaths and now in July there were five ward deaths. Did that occur to you at that time?

A. Well, we certainly were aware that it was a significant increase in deaths.

Q. Did you attach any significance I'm sorry.

A. I didn't compare that number with the previous year, but we were aware of the increase.

Q. Did you attach any significance to the fact that there had been five on-ward deaths







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2 in July at that time, that is to say, early in  
3 August?

4 A. The only significance we  
5 attach to it was that the patients all had extremely  
6 severe disease with the exception of Amber Dawson,  
7 whom we referred to the Coroner, and if you wish to  
8 bring in Laura Woodcock, June the 30th, that was  
9 also reported to the Coroner. But the others had  
10 extremely severe disease and we felt that that was  
11 a perfectly adequate explanation for the occurrence.

12 Q. Other than observing that,  
13 was it four of the five in July had extremely  
14 severe disease, did you in August seek any other  
15 explanation for the incidents of on-ward deaths  
16 that you had experienced in July?

17 A. Seek any other explanation?

18 Q. Any other explanation. Were  
19 you satisfied with the explanation for this unhappy  
20 group of deaths had been the severity of disease of  
21 these children?

22 A. We were thoroughly convinced  
23 of that. If you mean were we looking for a sinister  
24 meaning of death?

25 Q. I don't mean anything of the  
sort, Doctor, no. You were satisfied that this







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number of deaths was attributable to the severity of  
illness of the patients who had died, I take it?

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A. Yes, that was true. We didn't  
consider any other reason.

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Q. Is it your recollection that

7

there was a higher incidence of children with

8

severe disease on the ward in July than there had

9

been at any time in the preceding 18 months?

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A. I can't tell you that because

11

I wasn't always on the ward in the preceding 18

12

months, but I can tell you that there was a very

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distinct perception that we had a cluster of very

severe malformations at that time, July and August.

14

THE COMMISSIONER: Cluster of what?

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THE WITNESS: Cluster of very severe  
malformations.

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THE COMMISSIONER: Very severe

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mal...?

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MR. LAMEK: Malformations.

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THE WITNESS: Malformations of the

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heart.

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MR. LAMEK: Q. Doctor, believe me,

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I don't mean to be argumentative, but in order to

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ascribe to the severity of illness of your patients,

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the cause for this number of deaths in July, there

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2 must surely be some basis for saying that the  
3 severity of illness was of a higher order than  
4 it had been previously when similar numbers of deaths  
5 had not been experienced, is that fair?

6 A. I don't look at it in terms of  
7 numbers, I look at it in terms of the malformation of  
8 severity. If you take the three you mentioned  
9 first, the death in those three patients was really  
10 inevitable. So, there has got to be very severe  
malformations.

11 Q. Doctor, I understand, and I'm  
12 going to be coming to each of those patients, but  
13 equally I would take it that if the only cause of  
14 those deaths when they occurred was the severity of  
15 the malformations existing in those patients, then you  
16 would have expected I suggest a similar incidence  
17 of death whenever there was a similar incidence of  
malformations on the wards. Is that fair?

18 A. That would be true.

19 Q. And therefore, does it not  
20 follow, Doctor, that if the severity of malformation  
21 was the explanation for what you call the cluster  
22 in July, there must be some basis for saying that  
23 the severity of malformations was greater in that  
24 month than it had been at any time in the preceding  
25

I.e. if there had been, previously, a cluster of patients with similarly severe conditions, there would have been a similarly large cluster of deaths! Because there hadn't been a similarly large cluster of deaths before, he concludes that there had not previously been a cluster of similarly severely ill patients!





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18 months.

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A. That's probably a reasonable

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conclusion, yes.

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Q. And you have told us that that

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was the impression of the cardiologists. Are there

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any data available within the Hospital that would

8

help us to assess the validity of the impression?

9

A. I don't know whether we have

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that data. I understand there is data available,

it's being evolved through the CDC.

11

Q. All right, perhaps we will be

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hearing from that later.

13

Until you became aware of the existence

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of those data, did you have any hard information

upon which to base this impression?

15

A. No.

16

Q. The severity of malformation

17

experienced on the wards in July was greater than

18

it had been previously?

19

A. No, except that it would seem

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to us that if you had that cluster, if you had had

To tally  
circumstances!

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that cluster previously, there should have been a

similar result and the deaths would have been peaked

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at some other time.

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Q. Well, all right. Can we go

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back to that list of five children who died in July, Dr. Rowe. Did you observe, as at the beginning of August that each of the five of them, and, that is to say, Perreault, Bilodeau, Taylor, Dawson and Hoos had died between the hours of one o'clock and 3:30 in the morning?

A. I don't know that I was specifically aware of that. I think in general I was aware of the fact that these deaths, many of these deaths were occurring at night and I think that impression continued to grow subsequently.

Q. Well, as the story and the history developed, Doctor, perhaps we can look again at that impression. But if you had any awareness, and I think you just said you did, that many of these deaths were occurring at night, <sup>it</sup> ~~was~~ <sup>not</sup> ~~that~~ a matter upon which you remarked or which raised any question in your mind of any sort?

A. Not at that time it didn't, no. It did in August of course.

Q. Yes.

A. And subsequently.

Q. Now, were you aware that by the end of July, the nurses on the ward had become concerned about the number of deaths?







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A. I can only answer that by

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saying that I believe that it was in the early part  
of August that I became aware of their concerns.

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Q. And how did you become aware  
of that?

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A. That's a little uncertain in  
my mind because it has been suggested that I was  
talked to by several people, but I recollect only  
one conversation and that was with one of the nurse  
specialists on the ward who was concerned about the  
effect of the deaths on the nurses. They had been  
having obviously a difficult time with a series of  
deaths and they were concerned about, apparently,  
their inability to help these babies through, and  
this was a matter of concern to the nurse specialists  
who wondered if there was some way we could discuss  
these matters further.

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Q. Do you recall what if anything  
you said to the nurse specialist - who was that  
by the way?

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A. I believe - I cannot be  
sure which of the two nurse specialist it was but  
I believe it was Miss Carol Peterborough (sic).

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Q. I'm sorry, could you spell that?

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A. Miss Carol Peterborough.

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Q. Could you spell the second name, Doctor?

A. No, I can't.

Q. All right, we will get it somewhere.

A. We will get the name.

Q. Yes. Do you recall what if anything you said to her when she raised the question of the nurses' concerns?

A. I believe that I would have said to her that I was firmly convinced that the explanation for the deaths of these patients was the severity of the heart malformation and that it did make sense that we should address their concerns and to go over some of the details of these patients with them.

Q. And was it your thought at that time that a meeting be convened with cardiologists and nurses to discuss these deaths, or some of them.

A. Yes, that was the solution that I suggested after some discussions, some further discussions I believe.

Q. I think you said that conversation to the best of your recollection occurred in early August?





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3 A. Yes, somewhere in there. I  
4 can't remember the exact date, I don't have it on  
5 my calendar.

6 Q. And ~~it is~~ <sup>it</sup> is true, is it not,  
7 that the deaths on the ward continued to occur  
8 with unusual frequency during the month of August  
9 as well. Again, can we check and make sure that  
10 we have our chronologies in tune. On August 1st  
11 Philip Turner died, in his case, I believe at 2:15  
12 in the morning, Dion Shrum died at 8 o'clock in  
13 the evening, on August 19th Kelly Anne Monteith  
14 at 4:45 in the morning, on August 23rd Paul Murphy  
15 at 10:28 in the evening and on August 24th Antonio  
16 Velasquez at 4:25 in the morning. I take it that  
17 as those deaths occurred you were very shortly  
18 thereafter aware of them?

19 A. Yes.

20 Q. Daily meetings. Did you  
21 observe by the end of August that of the five deaths  
22 that had occurred in August, three had occurred  
23 in what I call the small hours of the morning, in  
24 this case between the hours of 2 o'clock and 5 o'clock?

25 A. I was aware that some of them  
had, I'm not sure exactly what number I reconized  
at that time.







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Q. You said a little earlier that you became aware as August progressed that many of these deaths were occurring in the very early hours of the morning. As at the end of August, of the 10 children who had died since July the 1st, did you observe that eight of them had died between the hours of, what is it, midnight and 5 o'clock?

A. I don't believe that I did a calculation of the number but I think I was aware that there were many that had died at night.

Q. Did it strike you or did it occur to you as being in any way unusual that many of these 10 children had died at night?

A. Yes, I think you would say it was a little unusual but at that stage the numbers weren't of a sufficient degree to really cause us great consternation about that, although, it was a factor in the discussions that we started in September.

Q. Now, do you recall any other contact with nurses during the month of August with respect to the continuing high number of deaths on the ward?

A. The nurse with whom I had most contact, since I am not generally on the

! 10 deaths  
in 2 hrs  
8 of them  
at night!







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Cardiac Ward as a Ward Chief, was the nurse specialist, and they used to see me on a fairly regular basis. So, I learned some of the nuances and things from them. So, there may have been other conversations with them. I know that it has been said there have been other conversations with fellows. There would have been discussions at the morning meetings about some of these matters but I don't have any distinct recollection of anybody making an appointment to see me and say, look, there has been too many deaths or there have been an expressive number of deaths on the floor.

Q. You say you would have learned, I think I have your language correctly, some of the nuances from the nurse specialists. Do you recall now any of the nuances which you so learned during the month of August?

A. No, I meant in respect, if there had been any particular issue that they wanted to discuss about that, they would have brought it to me I feel sure.

Q. Can you now recall the content of any such discussion, other than the one you have already described to us?

A. No.

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Q. You said there would be discussion at the morning meeting, referring, I take it, to the working meeting of cardiologists?

A. Yes. The working meetings are cardiologists and fellows and some nurses, not necessarily a huge number, but some nurses usually attend, and at least I would have expected that if there had been a very high level of concern that some of that would have filtered up to me some way or other.

Q. Yes. Do you have any recollection of any particular discussion at those morning meetings during the months of either July or August respecting the number of deaths that were occurring on the wards?

A. Nothing that seemed to rise up and make -- and become a major issue.

There was a lot of discussion about the deaths.

Q. Yes.

A. And people realized there were more than the usual run. It was nevertheless accepted as a cluster because of the nature of the disease that was found.

Q. Do you recall any discussion





1  
2 in any of the morning meetings about the time of  
3 day at which many of these deaths had occurred in  
4 July and August?

5 A. No, not as a specific point  
6 of contention.

7 Q. Well, Doctor, is it fair to  
8 say, and believe me I want to know your feelings,  
9 is it fair to say that by the end of August, although  
10 it was the impression as you have told us that these  
11 deaths were attributable to the severe malformations  
12 that were being seen, by the end of August there was  
13 some concern that ten children had died on the wards  
14 in the space of a few months?

15 A. I think we didn't make -- I  
16 don't think we voiced that as a major concern for the  
17 reasons I have mentioned, but we were obviously  
18 worried that the number was more than would have  
19 been predicted.

20 Q. All right. And what, then,  
21 did you do?

22 A. Then we set about having a  
23 series, a planned series of mortality conferences,  
24 mortality and morbidity conferences, as we chose to  
25 call them, and that was set up in such a way that  
they would be held on the cardiac ward so that nurses,





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cardiologists, fellows and residents would have an opportunity to attend.

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Q. Yes.

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A. And the time of the day was

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chosen particularly to make sure that nurses were able to come.

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Q. Doctor, I want to move to the first of those meetings, which I understand was held on September 5th, 1980, and in particular I want to discuss with you the three deaths which were reviewed at that meeting, and to go into the charts of each of those babies.

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That, Mr. Commissioner, is going to take a reasonable amount of time. It is 4:25. Is this an appropriate time to rise for the day?

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MR. COMMISSIONER: Yes, all right.

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MR. LAMEK: We can start afresh in the morning with the September 5 meeting?

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THE COMMISSIONER: Yes.

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All right, thank you. Are there minutes of those meetings?

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MR. LAMEK: Yes. I can make those available. I believe counsel have them, don't they?

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THE COMMISSIONER: They all seem to be maintaining a conspiratorial silence.

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MR. LAMEK: Yes, there are minutes,  
and I will have more copies available tomorrow.

THE COMMISSIONER: Yes.

MR. LAMEK: But most of them have them.

MR. STRATHY: Could I just raise one  
matter of procedure with you at this point? Now that  
we are entering the medical evidence --

THE COMMISSIONER: Excuse me,  
Mr. Strathy.

Thank you, Doctor, you may stand down  
if you would until tomorrow morning.

--- Witness withdraws

MR. STRATHY: It seems to me it might  
be appropriate to consider a change in the procedure  
in respect to cross-examination that we have been  
following, and specifically I was going to suggest  
that when Mr. Lamek is finished his examination in  
chief of the witness that Mr. Ortved and Mr. Scott  
or Mr. Roland be permitted to examine at that point  
before the rest of us get in and muddy the waters  
of the cross-examination.

An additional thing that I would  
suggest, though, is that Mr. Ortved and Mr. Scott  
also have an opportunity to re-examine after the  
various cross-examinations.





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Now I know you may say that is going to make things that much longer --

THE COMMISSIONER: No, no.

MR. STRATHY: -- but it really seems to me that counsel for the various witnesses, and medical witnesses particularly, will know what this witness is going to say and may well want to bring out matters that that witness can speak about prior to cross-examination.

THE COMMISSIONER: If you are concerned about your inability to answer you can always ask. You can always ask for an opportunity for further cross-examination, so that problem is resolved, but what do you say about that, gentlemen?

MR. ROLAND: Well, as far as I am concerned I will have no doubt some questions of this witness, but to a large extent from experience of the last couple of weeks I suspect most of my questions may arise out of cross-examination by other counsel.

THE COMMISSIONER: Yes. Well, you will have that according to Mr. Strathy's proposal, you will have two chances, but you can't save them all until the end because he would catch on very fast I think.

MR. ROLAND: I have no problem with it.





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I don't think I will have all that many questions of this witness.

THE COMMISSIONER: All right.

MR. ROLAND: For instance, arising out of Mr. Lamek's examination in chief because I have a fairly good sense of what Mr. Lamek is asking him and where he is going.

THE COMMISSIONER: Fine. Well, would you like to try it? Would you like to try it in this instance?

MR. ROLAND: I have no problem with that.

THE COMMISSIONER: Mr. Ortved what is your --

MR. ORTVED: I am quite happy with the arrangement whereby counsel for the witness went at the end.

THE COMMISSIONER: Yes, well, Mr. Strathy wasn't, that is the problem. He I guess feels that first of all - well, I guess the main problem and the only thing that really concerns me is which will be the most efficient. I don't want to have you coming up too often. If you are going to have a substantial cross-examination, it obviously would be best to have it early with the chance to re-examine. If you are not, it probably would be





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sensible just to give you one chance at the end.

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Well, let us try it. Let us try it tomorrow with you two gentlemen going first, and then if you want to, again at the end of all of the cross-examinations, you will come in.

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MR. ORTVED: I am in agreement.

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THE COMMISSIONER: Yes.

MS. SYMES: As we are entering into the medical evidence with respect to specific patients, it would be of great assistance to understand Dr. Rowe's evidence if we had the patients' charts.

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THE COMMISSIONER: Yes. We have three little men working day and night to try and get those things out. I don't know what the state of them is at the moment.

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MS. SYMES: Also it takes a long time to read them, and could they be released on a patient by patient basis so that we could do it overnight?

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MR. LAMEK: Mr. Commissioner, that is exactly what I propose to do. Tomorrow, as we come to each of the charts that were discussed and reviewed at the September 5th meeting, I propose to mark that chart as an exhibit.

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I have some difficulty in distributing copies of medical charts before they become exhibits in a proper sense.







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1 THE COMMISSIONER: Yes. There is a  
2 legal problem.

3 MR. LAMEK: But there will certainly  
4 be ample time for counsel to review those charts in  
5 the light of the transcript of the evidence to prepare  
6 for cross-examination.

7 I don't think Mr. Strathy's experiment  
8 as to the sequence of cross-examination of Dr. Rowe  
9 is going to be tested tomorrow, I am afraid.

10 THE COMMISSIONER: No.

11 MR. LAMEK: There is lots of time.

12 THE COMMISSIONER: I imagine that is  
13 all we can do except that there may be some patients  
14 who have released their medical information.

15 MR. LAMEK: I am not sure they have  
16 to other people. I have made available to counsel  
17 representing parents of individual children the charts  
18 of those children.

19 MR. STRATHY: Surely when the charts  
20 are all ready they could be tendered all at once as  
21 an exhibit through the witness.

22 MR. LAMEK: They could be. They could  
23 be.

24 THE COMMISSIONER: Well, they won't all  
25 be ready. They unfortunately won't all be ready this  
week.





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MR. LAMEK: Happily the first three ones are very slender ones, and Miss Symes will be able to read through them very quickly and comprehend everything in them.

THE COMMISSIONER: Well, I guess all we can do is the best we can do with respect to those.

I have seen some of them that were presented to me this morning and I was appalled by the size of the bundles. It is not something you would readily undertake to examine unless you had to.

MR. LAMEK: Mr. Commissioner, perhaps we can do this because I am very sympathetic to the suggestions which have been made. If we can persuade Dr. Rowe to step back into that witness box I can get him to identify the three charts that we are going to discuss tomorrow and mark them as exhibits now and then make them available to counsel. How would that be?

THE COMMISSIONER: He may have disappeared.

MR. LAMEK: If we can bring you back, Doctor, for just a moment?

DR. RICHARD DESMOND ROWE, Resumed  
CONTINUED DIRECT EXAMINATION BY MR. LAMEK:

Q Doctor, I am correct, am I not, at the meeting of September 5th, 1980 which you told





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us about just a few momnets ago, the deaths of three children were discussed, That is to say, Andrew Bilodeau, David Taylor and Phillip Turner?

A. Yes, that is correct.

Q. And the charts of those patients were reviewed and discussed at the meeting, were they?

A. The data from the charts were discussed.

Q. Yes.

THE COMMISSIONER: Sorry, the names were Bilodeau, Taylor?

MR. LAMEK: Bilodeau, Taylor and Turner.

THE COMMISSIONER: All right.

MR. LAMEK: Q. Doctor, I am showing you bound in a sequence which may or may not be familiar to you what I believe to be a copy of the Hospital's chart of Andrew Bilodeau. I would be grateful if you would look at it and tell me if you so recognize it?

A. Yes, I recognize it as Andrew Bilodeau.

MR. LAMEK: Thank you.

THE COMMISSIONER: We will make that an exhibit?

MR. LAMEK: Yes, please, Mr. Commissioner.

THE COMMISSIONER: What number, Mr. Registrar?





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THE REGISTRAR: 42.

THE COMMISSIONER: Exhibit 42, Andrew  
Bilodeau.

--- EXHIBIT NO. 42: Hospital Charts of  
Andrew Bilodeau.

MR. LAMEK: Q And next, Dr. Rowe,  
I am showing you what similarly I believe to be the  
contents of the Hospital's chart of David Taylor. Do  
you recognize that for me, please?

A. I recognize that as the chart  
of David Taylor.

MR. LAMEK: Thank you.

The next exhibit, please, Mr.  
Commissioner?

THE COMMISSIONER: Exhibit 43.

--- EXHIBIT NO. 43: Hospital Charts of  
David Taylor.

MR. LAMEK: Q And finally a bound copy  
of what I believe to be the Hospital's charts of  
Phillip Turner. And do you so recognize that?

A. Yes. I recognize that as the  
chart of Phillip Turner.

MR. LAMEK: Thank you very much, Doctor.

THE COMMISSIONER: Exhibit 44. I take  
it those will be distributed.

--- EXHIBIT NO. 44: Hospital Charts of  
Phillip Turner.







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MR. LAMEK: Yes, I will make those available to counsel this evening, sir. I regret to say because of the magnitude of the task of reproducing all these charts that I am going to have to ask counsel if they would be prepared to share the charts on the same basis as the transcripts of the Preliminary Inquiry which were shared.

That applies to some counsel and I trust that won't pose any serious difficulty.

Thank you, sir.

MR. SHINEHOFT: I have a problem, Mr. Commissioner. I am from out of town and it may be difficult for me to share. I would ask if perhaps a copy could be made available for me.

THE COMMISSIONER: I hope you are not attending some function this evening and be unable to read them in any event. It is none of my damn business and don't answer that question, but it is an expensive *undertaking* ~~outing~~ to complete these so only if you must - if you want it for that particular night and you intend to be reading it that particular night, then I think that is a legitimate request. If you don't intend to be reading it that particular night, I have some doubts about it, that is all.

MR. SHINEHOFT: I understand, sir,





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there is some expense involved. I only meant it in the context that it would be difficult for me to share it. I don't mind picking it up the next day, but I would ask my friend to supply me with a separate copy.

THE COMMISSIONER: Well, whatever you can do.

MR. LAMEK: Perhaps Mr. Shinehoft and I can talk about that later.

THE COMMISSIONER: Yes. All right. Anything else then?

All right then until ten o'clock tomorrow morning.

--- Whereupon the Hearing was adjourned at 4:35 p.m. until Wednesday, the 13th day of July, 1983, at 10:00 a.m.







